DOCUMENT RESUME

ED 306 042 RC 016 908

TITLE	Mental Health and the Elderly: Issues in Service Delivery to the American Indian and the Hispanic Communities. Part II. Hearing before the Select Committee on Aging. House of Representatives, One Hundredth Congress, Second Session (Denver, Colorado).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-Comm-Pub-100-673
PUB DATE	27 May 88
NOTE	69p.; For Part I, see UD 026 502.
AVAILABLE FROM	Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	*American Indians; Federal Aid; *Health Needs; *Health Services; Hearings; *Hispanic Americans; *Mental Health; *Older Adults; Trust Responsibility (Government)
IDENTIFIERS	Congress 100th

ABSTRACT

This field hearing by the House Select Committee on Aging produced testimony on the mental health problems and service delivery needs of American Indian and Hispanic American elderly. A director of research and two American Indian advocates: (1) pointed out the high rate of depression among Indian elderly due to physical impairments and deprived living conditions; (2) described service-related and cultural factors contributing to low use of mental health services by Indian elderly; (3) outlined the specific problems and stresses of urban Indians; and (4) proposed legislative and service delivery strategies. A Colorado state official outlined barriers to delivery of mental health services to Hispanic elderly. An Hispanic advocate emphasized the need for outreach programs with bilingual, bicultural staff. The panel of witnesses discussed: (1) the need for home health agencies and community-based services for Hispanic and Indian elderly; (2) language and cultural barriers between generations, resulting intergenerational conflict, and mental health consequences for the elderly; and (3) the right of each tribe to its own definition of "Indian." The Committee Chairman called for Indian organizations to collaborate and draft legislative proposals covering the relevant needs of the Indian community, and asked Hispanic organizations to do likewise. Testimony from four mental health professionals covered funding issues, training to provide culturally sensitive outreach staff, and the particular problems and needs of the rural elderly. (SV)

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MENTAL HEALTH AND THE ELDERLY: ISSUES IN SERVICE DELIVERY TO THE AMERICAN INDIAN AND THE HISPANIC COMMUNITIES

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MAY 27, 1988, DENVER, CO

Comm. Pub. No. 100-673

PART II

Printed for the use of the Select Committee on Aging

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MENTAL HEALTH AND THE ELDERLY: ISSUES IN SERVICE DELIVERY TO THE AMERICAN INDIAN AND THE HISPANIC COMMUNITIES

Friday, May 27, 1988

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Denver, CO

The committee met, pursuant to notice, at 9:30 a.m, in the Colorado Psychiatric Hospital Auditorium, University of Colorado, 8th and Birch Street, Denver, Colorado, Hon. Edward R. Roybal (Chairman of the Select Committee on Aging), presiding.

Members present. Representatives Roybal and Bilbray.

Staff present: Manuel R. Miranda, Staff Director; Edgar E. Rivas, Professional Staff; and Diana Jones, Staff Assistant.

The CHAIRMAN. The hearing will come to order.

Ladies and gentlemen, it is a real privilege for us to be in Denver this morning, and to conduct this hearing that will result in legislation to be submitted to the Congress of the United States.

With me this morning is the gentleman from the State of Nevada, Congressman Bilbray, who is a member of the committee. He has also asked us to go to his State and conduct a hearing there, and we hope that we will be able to do that before the end of the year.

I will now recognize the gentleman from Nevada, Congressman Bilbray, to make an opening statement, and I will follow that with my own opening statement and then proceed with the hearing.

Congressman Bilbray.

STATEMENT OF REPRESENTATIVE JAMES H. BILBRAY

Mr. BILBRAY. Thank you.

Mr. Chairman, I congratulate you on your leadership to hold field hearings on Mental Health in the Elderly, with special emphasis on issues and service delivery to the American Indian and the Hispanic Community, an issue of little awareness by the public yet of great public consequences. It is estimated that 15 to 25 percent of those over the age of 65 have significant mental health problems, and that in 1985, 85 percent of older Americans needing mental health services went without them.

Like Colorado, Nevada also has American Indians and Hispanic Communities that need mental health care for the elderly. I am here today with the hope of gaining insight from the testimony and a great knowledge of the subject.

I believe the health problems of older Americans, such as dementia, including Alzheimer's Disease, and other forms of severe cognitive impairment must be better understood by the public and Congress in order to effectively overcome the many obstacles that exist.

One obvious obstacle is the misperception by a vast majority of the public that the aging process and mental health problems go hand in hand. All too often, the stereo-typical senior citizen comes as a senile individual.

Older Americans with mental health disorders are labelled senile for no other reason than that the lack of knowledge by the people of this Nation and the government. We must overcome this ignorance and realize that many older Americans with mental health problems can be treated. Therefore, increasing the quality of their lives.

Mr. Chairman, hearings such as these bring to higher awareness the entire issue of mental health and the elderly, with a special emphasis on the mental health needs of older minorities.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. Thank you, Congressman. Ladies and gentlemen, the purpose of today's hearing, which is the second of three field hearings organized by the House Select Committee on Aging, is to examine the mental health problems and service delivery needs of our country's American Indians and Hispanic elderly.

On March 2nd of this year, the Aging Committee held a very successful hearing in Washington, D.C. At that time, we introduced the report entitled, "The Elderly Mental Health Reform Act." This initial draft, will be modified as the committee completes the process of gathering the necessary information or purposes of introducing legislation which will adequately address the mental health needs of our elderly.

The committee has been doing some work with regard to this problem as it affects the elderly in general, but we have not focused on the American Indian or Hispanic elderly. We want to do that.

While our information about American Indian and Hispanic elderly mental health needs are limited, we do know that both of these populations are severely underrepresented at all levels of the mental health system. This is an astonishing fact when one stops to consider the high degree of unemployment and educational dropout rate, family fragmentation, and the dehumanizing racial discrimination that our American Indians and our Hispanic Community face on a daily basis. The elderly within these two communities are in even greater jeopardy because of both their age status and their lifelong exposure to these debilitating factors.

Without question, our country's mental health system is in serious need of reform in relation to meeting the needs of our elderly citizens in general, and our culturally-diverse elderly specifically. This neglect will be documented when the committee report is complete. The report again will be made available to all interested parties throughout the country, as well as Members of both the House of Representatives and the Senate.

The report will also be made available to State legislators involved with health legislation. It is my hope that the report will generate enough interest among the various State health committees to stimulate the development of a national conference leading to the implementation of new solution

Once these legislators get to that point, then the next step will be to reach out and include these mental health experts, like those who will testify today, to help us in the drafting of legislation that will address itself to the problems at hand.

I am not referring to a dream that we just talk about, because I think it is something that can be accomplished. Most of the time, we draft legislation that affects a particular industry without even consulting or including that industry in the drafting of that piece of legislation.

In the field of health, I think we have to do a lot more. I think we have to use the intellect, we have to be sure that we present a program that can work, and that as we do that, we will hold them and keep the cooperation of all the individuals that are involved.

That is, in general, what we have in mind. We hope we will be able to accomplish it, and we will proceed then with the hearing and get the information that these individuals will each give the committee.

I would like to, first of all, acknowledge the presence of the following members of the panel: Spero Manson, Ph.D. Curtis D. Cook. James Berg. Fred Acosta. Jose Mondragon. All these five gentlemen then will make their presentation.

I will ask the first to proceed in any manner that you may desire. Mr. Manson, please start off the discussion.

STATEMENT OF SPERO M. MANSON, PH.D., ASSOCIATE PROFESSOR AND DIRECTOR, NATIONAL CENTER FOR AMERICAN INDIAN AND ALASKA NATIVE MENTAL HEALTH RESEARCH, UNIVERSITY OF COLORADO HEALTH SCIENCES CENTER, DENVER, CO

Dr. MANSON. Thank you, Mr. Chairman, both for your presence here in Denver today as well as the invitation to be a part of these hearings, and to you as well, Congressman Bilbray.

Health problems play a large role in the lives of older American Indians. For example, 73 percent of the elderly Indian population is estimated to be mildly to totally impaired in their ability to cope with the basics of daily living, according to a 1981 report by the National Indian Council on Aging, in which I had a small part. Forty percent of all adult Indians have some form of disability. Liver and gall bladder disease rheumatoid arthritis and diabetes also occur far more frequently within this special population than in any other. Other health problems include obesity, hypertension, pneumonia, poor vision, and dental decay.

The impact of these diseases is reflected in the significantly higher rates of depression among Indian and Native elderly when compared to non-Indian elderly. The physical as well as psychological consequences contribute substantially to the decreased longevity of this population when compared to whites. I could continue to list the health-related problems facing older American Indians and

Alaska Natives. Indeed, four recent publications detail the excess morbidity and mortality and, in turn, disparity when compared to whites as well as other ethnic minorities. These publications include the Indian Health Care Report released by the Office of Technology Assessment in 1986; Report of the Secretary of HHS Task Force on Black and Minority Health in 1985; Bridging the Gap Report by the Task Force on Parity in Indian Health Services in 1986; and its companion document, Indian Health Conditions, released in the same year, and a monograph from our own program, entitled Health and Behavior Among American Indians and Alaska Natives.

However, the most telling examples embodied in the following case study were recounted in some of our own work. This particular case involves B.H. B.H. is an elderly Navajo man suffering from Parkinson's Disease. B.H. lives with his wife of 40 years in a one room earth hogan without electricity or running water. His wife suffers from severe arthritis in her legs and cannot walk even with the aid of a walker.

A wheelchair would be of no use to her as the sand and the mud during the rainy season surrounding their hogan would not support the narrow gauge wheels of the wheelchair, and she would become stuck within several yards of leaving her hogan.

B.H. also has great difficulty getting around. He usually spends most of his days sitting in the very worn easy chair, alert, except for short periods following the administration of his medication.

Tremors and weakness in his extremities make it very difficult for him to accomplish even the most simple chores, such as carrying drinking water inside from barrels stored outside the hogan.

B.H. and his wife could not care for themselves were it not for three important factors. A tribal home health care program pays their daughter-in-law minimum wage to spend 4 hours a day with them helping with cooking, washing and other chores. The daughter-in-law, even though she lives 2 miles away, would probably provide these services for free. However, the income she earns from this program is critical in keeping her family's pick-up running.

Her husband, B.H.'s son, has worked only 4 months during the last year. His sporadic wage income, his wife's meager salary and the contributions from his parents, whose combined income is about $500 per month, help support him, his wife and their four children.

In return, the son's services are critical to the support of his parents. He hauls wood for fuel and water for drinking, cooking and bathing. He contributes meat from his wife's small herd to his parents' diet, which is otherwise prohibitively expensive.

He also provides critical transportation to a hospital some 45 miles from their residence. At least once a week, he takes his parents on an outing to the trading post where they socialize and purchase necessities. Both of his parents' degenerative illnesses are monitored by the community health representative who takes vital signs, delivers medicine and tries to anticipate any acute episode.

These situations find their parallels in the cities as well, not just on such isolated and rural areas as the Navajo reservation. Examples of these will be brought to your attention throughout this morning.

One expects that the mental health consequences of these circumstances are considerable, yet little has been done to actually demonstrate how such deprivation translates into the emotional and mental health problems or levels of morale and life satisfaction among older American Indians. In fact, to my knowledge, only six studies have been published which address this topic, and they are essentially regional and focus on very specific aspects of the process of stress, illness and coping.

Nonetheless, these efforts provide some insights into the nature and magnitude of the problem. I have had the privilege to be involved in several of these studies.

For example, in 1980, I and several colleagues studied the daily problems faced by 231 older Indians living in two Pacific Northwest reservations and in a nearby city. Our findings indicated that certain types of problems, particularly physical illness and resulting limitations on activities of daily living, occur with alarming frequency among these individuals, that they resist easy solution in terms of the social, economic and psychological resources available to them, and, consequently, engender high levels of persistent stress.

The vast majority of these older adults was unaware of potentially appropriate services, did not know how to seek information about needed care, and expressed concern about what people might think of them if they did seek such help.

Over 80 percent of this sample of 231 older adults had seen a primary health care provider within the month prior to interview. Slightly less than 10 percent of those experiencing significant stress due to their physical health problems reported that the providers had inquired at all about their emotional well-being.

Indeed, only 3 percent were offered specific information about supportive services. Clear urban and rural differences emerged as well, revealing that the older American Indians that we were involved with that had lived in the city were even more disadvantaged than their reservation counterparts.

More recently, I and my colleagues have been annually interviewing 320 older members of four Pacific Northwest reservation communities about various aspects of their mental and physical health status. These are individuals who were originally selected because they had been seen for the first time in a local health clinic during 1984 for one of three chronic physical health problems, specifically rheumatoid arthritis, diabetes and eschemic heart disease.

Using a widely-accepted screening tool, over 32 percent of these individuals were deemed to be suffering from clinically significant levels of depression, more than twice the rates reported by recent studies of older whites with similar physical health problems.

Subsequent medical chart reviews indicated that less than 7 percent of these individuals' primary care providers, physicians and community health nurses, had observed and at least documented these symptoms in their medical records.

The reported life satisfaction of these patients was similarly low. Again, with little apparent recognition by providers. There also is a strong relationship among these depressive symptoms, low life sat-

isfaction, and these older Indian patients' ability to perform activities of daily living.

It is not too surprising then that they are generally dissatisfied, as they told us, with the nature of the health care available to them.

Several years ago, we conducted another study among the small number, about a 104, primary care providers who serve American Indians in two western States. Our focus was on their attitudes toward the perceptions of long-term care. Their definitions of long-term care almost invariably centered around notions of institutionalization.

Eighty-one percent of these providers named nursing homes as the only or primary service setting for such care. Furthermore, when asked about the service objectives of long-term care, the vast majority of these providers emphasized rehabilitation and protection of these patients, but seldom mentioned promotion or prolonged longevity.

Lastly, in response to the degree to which long-term care is concerned with enhancing patient status, these same providers indicated almost without exception that it was primarily physical functioning and rarely noted psychological or social functioning, which was among the ready choices available to them.

Unfortunately, our recognition and understanding of these problems has been slow to mature in light of extensive documented need. Considerable programmatic emphasis has been placed on identifying and intervening in similar circumstances among the elderly in the general population. New preventive and promotive technologies have resulted, yet little has found its way to Indian and Native communities.

A concerted effort should be undertaken to ameliorate the physical and psychological disabilities that plague our older American Indians and Alaska Natives to lessen the crushing burden that their illnesses place on already-stressed family care-givers and to assist local communities in developing innovative responses to the ensuing needs.

[The prepared statement of Dr. Manson follows:]

AMERICAN INDIAN ELDERLY: MENTAL HEALTH STATUS AND SERVICE NEEDS

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Health problems play a large role in the lives of older American Indians (Schulz & Manson, 1984). For example, 73% of the elderly Indian population is estimated to be mildly to totally impaired in their ability to cope with the basics of daily living (National Indian Council on Aging, 1981). Forty percent of all adult Indians have some form of disability (Indian Health Service, 1978). Liver and gall bladder disease, rheumatoid arthritis, and diabetes also occur far more frequently within this special population than in any other (Sievers & Fisher, 1981). Other health problems include obesity, hypertension, pneumonia, poor vision, and dental decay (West, 1974). The impact of these diseases is reflected in the significantly higher rates of depression among Indian elderly when compared to non-Indian elderly (National Indian Council on Aging, 1981; General Accounting Office, 1977). The physical as well as psychological consequences contribute substantially to the decreased longevity of this special population when compared to Whites (Hill & Spector, 1971; Sievers & Fishers, 1981; Manson & Callaway, in press).

One can continue to list the health-related problems facing older American Indians and Alaska Natives. Indeed, four recent publications detail their excess morbidity and mortality and, in turn, disparity when compared to Whites as well as other ethnic minorities. These publications include: (1) Indian Health Care (1986) released by the Office of Technology Assessment; (2) Report of the Secretary's Task Force on Black and Minority Health (1985); (3) Bridging the Gap: Report on the Task Force on Parity of Indian Health Services (1986) and its companion Indian Health Conditions (1986), and (4) Health and Behavior Among American Indians and Alaska Natives: A Research Agenda for the Biobehavioral Sciences (Manson & Dinges, 1988). However, the most telling example is embodied in the following case study recounted by Manson and Callaway (1988):

> B.H. is an elderly Navajo man suffering from Parkinson's disease. B.H. lives with his wife of 40 years in a one room earth covered hogan without electricity or running water. B.H.'s wife suffers from severe arthritis in her legs and can not walk even with the aide of a walker. A wheelchair would be of no use to her as the sand and mud (during the rainy season)

surrounding her hogan would not support the narrow gauge wheels of a wheelchair and she would become stuck within several yards of leaving her hogan. B.H. also has great difficulty getting around. He usually spends most of the day sitting in a very worn easy chair, alert except for short periods following the administration of his medication. Tremors and weakness in his extremities make it very difficult for him to accomplish even the most simple chores, e.g. carrying drinking water inside from barrels stored outside the hogan.

B.H. and his wife could not care for themselves were it not for three important factors. A Tribal Home Care Program pays their daughter-in-law minimum wage to spend four hours a day with them, helping with cooking, washing and other chores. The daughter-in-law, even though she lives two miles away, would probably provide these services for free. However, the income she earns from this program is critical in keeping her family's pickup running. Her husband, B.H.'s son, has worked only four months during the last year. His sporadic wage income, his wife's meager salary and contributions from his parents (whose combined income is about $500/month) help support him, his wife and their four children. In return, the son's services are critical to the support of his parents. He hauls wood for fuel and water for drinking, cooking and bathing. He contributes meat from his wife's small herd to his parent's diet (prohibitively expensive otherwise). He also provides critical transportation to a hospital some 45 miles from their residence. At least once a week he takes his parents on an outing to the Trading Post where they socialize and purchase necessities.

Both of his parent's degenerative illnesses are monitored by a Community Health Representative (CHR) who takes vital signs, delivers medicine and tries to anticipate any acute episode. During the last three years due to federal budget cuts the Navajo Tribe has lost over $100 million dollars in revenue. Further funding for CHR's and Home Health Care are problematic. In addition, the Indian health Service (IHS) has cut its field health staff in half, doubling the area of responsibility for the remaining staff. The reservation economy is extremely bleak. B.H.'s son must compete for wage employment in an environment of 65% unemployment - although the Census would count him as being employed because he had some employment during the 12 month reference year.

B.H. and his wife's diseases will become progressively worse but it is doubtful whether he or his wife would accede to being placed in a nursing home. However, if

> they were placed in such an institution it is clear that outlays paid for their support by the federal government would be 20 to 40 times the amount now being spent to support their portion of the CHR and Home Health Care programs.

These situations find their parallels in our cities as well. Examples of which will be brought to your attention later this morning.

One expects that the mental health consequences of these circumstances are considerable. Little has been done, however, to demonstrate how such deprivation translates into emotional and mental problems or low levels of morale and life satisfaction among older American Indians. Only six studies have been published which address this topic. They are essentially regional and focus on specific aspects of the stress, illness, and coping process. Nonetheless, these efforts provide some insight into the nature and magnitude of the problem.

In 1980, I and several colleagues (Manson, in press) studied the daily problems faced by 231 older Indians living in two Pacific Northwest reservations and in a nearby city. Our findings indicated that certain types of problems--particularly physical illness and resulting limitations on activities of daily living--occur with alarming frequency among these individuals, resist solution in term of the social, economic, and psychological resources available to them, and, consequently, engender high levels of persistent stress. The vast majority of these older adults were unaware of potentially appropriate services, did not know how to seek information about needed care, and expressed concern about what people might think of them if they did seek such help. Over 80% of this sample had seen a primary health care provider within the month prior to interview. Slightly less than 10% of those experiencing significant stress due to physical health problems reported that their providers had inquired about their emotional well-being; only 3% were specific offered information about supportive services. Clear urban/rural differences emerged, revealing that the older American Indians who lived in the city were even more disadvantaged than their reservation counterparts.

More recently, I and my colleagues have been annually interviewing 320 older members of four Pacific Northwest reservations about various aspects of their mental and physical health status. These individuals were originally selected because they had been seen for the first time in a local health clinic during the 1984 calendar year for one of three chronic physical health problems: rheumatoid arthritis, diabetes, and ischemic heart disease. Using a widely accepted screening tool, over 32% of these individuals were deemed to be suffering from clinically significant levels of depressive symptoms, more than twice the rates reported by recent studies of older Whites with similar types of physical illnesses. Subsequent medical chart reviews

indicated that less than 7% of their primary care providers--physicians and community health nurses--had observed (or at least documented) these symptoms. Their reported life satisfaction was similarly low; again with little apparent recognition by providers. There also is a strong relationship among these depressive symptoms, low life satisfaction, and ability to perform activities of daily living. It is not too surprising, then, that they are generally dissatisfied with the nature of the health care available to them.

Several years ago, we conducted another study among a small number (n=104) of primary care providers who serve American Indians in two western states. Our focus was on attitudes toward and perceptions of long-term care. Their definitions of long-term care almost invariably centered around institutionalization: 81% (n=84) of them named nursing homes as the only or primary service setting. Furthermore, when asked about the service objectives of long-term care, the vast majority of these providers emphasized rehabilitation and protection, seldom prevention or prolonged longevity. Lastly, in response to the degree to which long-term care is concerned with enhancing patient status, the respondents invariably selected physical functioning and rarely noted psychological or social functioning.

Unfortunately, our recognition and understanding of these problems has been slow to mature in light of extensive documented need. Considerable programmatic emphasis has been placed upon identifying and intervening in similar circumstances among the elderly in the general population. New preventive and promotive technologies have resulted. Yet little of this has found its way to Indian and Native communities. A concerted effort should be undertaken to ameliorate the physical and psychological disabilities that plague older American Indians, to lessen the crushing burden that their illnesses place on already stressed family care-givers, and to assist local communities in developing innovative responses to the ensuing needs.

The CHAIRMAN. Thank you. The Chair will recognize Mr. Curtis D. Cook.

STATEMENT OF CURTIS D. COOK, EXECUTIVE DIRECTOR, NATIONAL INDIAN COUNCIL ON AGING

Mr. COOK. Thank you, Mr. Chairman, Mr. Bilbray. It is a pleasure to be with you and our distinguished guests this morning, and to speak on behalf of the nearly 200,000 American Indian and Alaskan Native elderly in our country.

I represent the National Indian Council of Aging, an organization which was formed in 1976 through the concerted effort of representatives from more than 175 different tribes, in Phoenix, Arizona.

The purpose of our organization is that of advocating for the needs of Indian elders, and during the process of advocating, we have sought to develop data, we have sought to conduct research surveys, and to find specific information with regard to their status in various categories: in health, housing, transportation, income support, access to entitlement services and other kinds of services.

However, we have found that there is a great lack of information on the mental health status of Indian elders, and I come to you today as an advocate speaking on behalf of these Indian elders and speaking to the need that exists.

My perspective is not that of a policymaker, not that of a service provider, and not that of a clinical professional. My perspective is that of an advocate. There are others here on this panel and who are here at this university who are eminently qualified to present the professional perspective.

But something happens to an advocate when he begins to see firsthand the situation that exists in a deprived population. My experience with Indian people started 24 years ago. I began my experience by living with an elderly Zuni Indian couple in New Mexico.

I lived there for 2 years in their home, shared their home with them, learned to speak the language, and learned to be sensitive to their needs. And, so, if my testimony and if my advocacy efforts in the days ahead tend to be that of an impassioned compassionate person, it is because I have seen firsthand the conditions which exist among this needy population. Precious people in the midst of great need and it disturbs me to see that policymakers, service providers, even legislators, Mr. Chairman, do not seem to sense that same level of urgency, that same level of compassion, that same level of recognition that the needs are real, that these are real people, and that they need to have response to their needs.

One conclusion that I have come to in the course of my 24 years of service for Indian programs is that Indian elders do not seek out services. They wait and they abide until someone intervenes into their circumstances.

In fact, we have discovered that the rate of access or the rate of utilization of mental health services by Indian elderly people is less than 6 percent, whereas they represent nearly 8.5 percent of the general population among Indian people.

This underutilization of mental health services by Indian elders is due to many, many different reasons, but these are some of the

prevalent ones. Limited access due to lack of transportation, information and resources. Lack of outreach on the part of mental health service providers. Lack of a specialized focus within the Indian health service delivery system on gerontological study and geriatric health care.

A lack of documented information on how Indian elders view mental health and how they view the programs and the providers in the field of mental health. This last-mentioned barrier results in the failure of service providers and policymakers to design mental health service approaches which are appropriate to the social and cultural setting in which the elders have need of services.

But of even greater concern to advocates for Indian elders and informed professionals is the fact that the daily living circumstances of Indian elders pose a continual threat to their ability to maintain a healthy outlook on their daily lives and their future.

That is to say, our own studies have revealed and my experience has confirmed that there is a high level of acceptance on the part of Indian elders with sets of living circumstances to which no one in a caring society should be subjected.

Survey results compiled by NICOA in the years 1984, 1986 and 1987 all indicated that elders typically resign themselves to a fatalistic view of their circumstances in which they have learned through experience that things are never going to get any better for them; and, so, they face each day with a sense of resignation. Acquiescently, they lower their expectations. All too often I have heard in my own personal visits in Zuni homes and the homes of many other Indian elders around the country comments such as, "well, it is good enough for an Indian". My feeling is that it is not good enough for anyone in a caring society.

We should regard this all too frequent passive acceptance of circumstances as an unacceptable and sad commentary on the success of our service delivery systems to address the need to build around the vulnerable and frail in our midst a caring society.

Dr. Spero Manson and Donald Callaway, in their article, "Health and Aging Among American Indians: Issues and Challenges for the Bio-Behavioral Sciences", have characterized the daily lives of Indian elders, especially the old old, in this manner: "Growing older presents great difficulties for a sizable segment, perhaps 30 percent, of America's aged population. Being Indian and being old intensifies these difficulties, but being an Indian over the age of 75 and living in a rural area may represent being a member of the most discriminated segment of American society."

Another factor which contributes to the Indian elders' low utilization rates pertaining to mental health services is the matter of how they view and how they define mental health. For many Indian elders, the ultimate in mental well-being is to be fully compliant with their own religious beliefs and with their environment, and to live in harmony with nature.

This predisposition on their part to adapt to their environment may also lead them to accept less than desirable circumstances as their lot in life. Therefore, they do not seek change in their circumstances. They do not seek help to bring about any improvements until there is some contact or intervention initiated from an out-

side source, a family member, social worker, or other service provider.

If, then, we are conscientious and compassionate advocates and service providers we must seek ways in which to enhance the environment to which the elders adapt themselves. We must teach young people, communities and service providers, to respect their elders. We must take the initiative to build around these elders a truly caring society.

How can this be done? And given the many barriers to access and utilization, what approaches can be used to address this very complex problem? Here are a few recommendations for your committee, Mr. Chairman.

Legislation is needed which would authorize funds to support a nationwide comprehensive study, perhaps cosponsored by the National Institute of Mental Health, the Administration on Aging, and the Indian Health Service, to assess both the status of Indian elderly mental health and their methods of coping with their environment.

Included in this study should be a thorough discussion of the elements which are found to be essential to maintaining elders in meaningful roles within their families and their communities, and the various components of a community-based service delivery system, which will contribute to an environment which protects their mental well-being and enhances their quality of life.

I would like to suggest that the people most eminently qualified to conduct such a study would be Dr. Manson and his colleagues right here at this university because they are the leaders in the field of Indian elderly mental health studies.

Number 2. Legislation is needed which will provide funding for model projects and dissemination of information on the mental health services approaches which are most appropriate for Indian communities. Ideally, these model projects would be developed and conducted by Indian research and program development organizations, which would presumably have a better ability to interpret the data which is culturally determined and culturally based.

Number 3. Mental health and social service workers should be required to conduct outreach efforts in Indian communities, to identify at-risk elders, and to develop treatment/intervention plans for them, based on the observation that facility-based intake approaches have not been sufficient to assure the appropriate utilization levels by Indian elders.

Number 4. Para-professional service providers, such as community health representatives, home health aides, and homemaker service providers, should be trained by way of resources made available through special appropriations to detect and report signs of developing mental health problems in Indian elders with whom they come in contact in the course of their daily home visits.

Number 5. In coordination with Number 3 above, multi-disciplinary teams should be formed through collaborative efforts of the Indian Health Service, Bureau of Indian Affairs, and various tribal service programs to develop comprehensive case management systems and treatment plans for at-risk elders in Indian communities or rural areas.

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Again, legislation authorizing funding to support the implementation of these case management systems is badly needed.

Funds should be made available to permit tribes or Indian health facilities to hire and train patient advocates to act as special interpreters and ombudsmen for Indian elders in need of services, who do not understand the system, do not understand the language of the service provider, and do not understand even why they are there.

More often, they rely on their own traditional spiritual means of dealing with their circumstances. Education is needed. Assistance is needed and certainly advocacy is needed in every instance where there is an Indian elder not understanding and not effectively negotiating the system.

It is about time someone cared enough to establish this kind of advocacy.

Number 7. The Indian Health Service should be required to establish an area of gerontological focus within its service planning and delivery system, and to establish specialized geriatric health care as a budgeted line item at every Indian Health Service facility based on the assumption that the provision of adequate medical care is conducive to appropriate mental health care for the elders who come in contact with IHS service facilities and service providers.

Mr. Chairman, there is much more I could say. I could relate to you personal experiences of Indian elders whom I have found to be in great need and, yet, who express that they are generally well satisfied with their life circumstances, but I submit, Mr. Chairman, that that is because they have learned that it is never going to get any better.

We look to you, we look to Congressman Bilbray and your colleagues, to make changes that will improve the circumstances in which our Indian elders exist.

This concludes my remarks. Thank you.

[The prepared statement of Mr. Cook follows:]

Statement of

Curtis D. Cook

Executive Director

National Indian Council on Aging

Before the

House Select Committee on Aging

May 27, 1988

Denver, Colorado

Statement of
Curtis D. Cook
Executive Director
National Indian Council on Aging

Mr. Chairman, and distinguished members of the House Select Committee on Aging, it is a privilege for me to appear before you today and to present testimony on behalf of more than 200,000 American Indian and Alaskan Native elders. I am Curtis Cook, the Executive Director of the National Indian Council on Aging, an organization which was formed in 1976 by representatives of more than 175 Indian tribes for the purpose of advocating for their elders. The perspective I bring to these hearings is not that of a policy maker, a service provider or a clinical professional; other witnesses invited here today are imminently qualified to present those viewpoints. I speak rather from the perspective of an advocate; and my testimony is based upon surveys and studies conducted by the National Indian Council on Aging and others over the past ten years. My viewpoint is also based upon my own observations from 24 years of service in Indian programs, as I have seen firsthand the difficult and harsh environment in which the majority of Indian elders across the nation must seek to live out their lives in dignity and good health. The conclusions of the NICOA studies have been confirmed again and again in my experience as I have witnessed the many factors which mitigate against the ability of Indian elders to receive adequate services (including mental health services).

One conclusion, which is so apparent in all of the information available to us, is that the Indian elders utilize mental health services at a very low rate (6.4%) compared to their numbers in the general Indian population (8.5%). The reasons for

the under-utilization of mental health services by Indian elders are many, but the most prevalent are:

-- limited access (due to lack of transportation, information and resources);

-- lack of outreach on the part of mental health service providers;

-- lack of a specialized focus within the Indian Health Service delivery system on gerontological study or geriatric health care; and

-- a lack of documented information on how the Indian elders view mental health, and how they view the programs and providers in the mental health field.

This last-mentioned barrier results in the failure of service providers and policy makers to design mental health service approaches which are appropriate to the social and cultural setting in which the elders have need of services. But of even greater concern to advocates for Indian elders is the fact that the daily living circumstances of Indian elders pose a continual threat to the ability of Indian elders to maintain a healthy outlook on their daily lives and on their future. That is to say, our own studies have revealed that there is a high level of acceptance on the part of Indian elders with sets of living circumstances to which no one in a "caring society" should be subjected. Survey results compiled by NICOA in the years 1984, 1986 and 1987 all indicated that Indian elders typically resign themselves to a fatalistic view of their circumstances in which they have learned through experience that things are never going to get any better for them; and so, they acquiescently

lower their expectations. All too often I have heard during my visits in the homes of Indian elders the statement: "Well, it's good enough for an Indian." We should regard this all-too-frequent passive acceptance of circumstances as an unacceptable and sad commentary of the success of our service delivery systems to address the need to build around the vulnerable and frail in our midst a truly caring society. Doctors Spero Manson and Donald Callaway, in their article, "Health and Aging Among American Indians: Issues and Challenges for the Biobehavorial Sciences," characterized the daily life of Indian elders (especially the old old) this way:

> Growing older presents great difficulties for a sizeable segment (perhaps 30%) of America's aged population. Being Indian and being old intensifies these difficulties, but being an Indian over the age of 75 and living in a rural area may represent being a member of the most discriminated segment of American society.

Another factor which contributes to the Indian elders' low utilization rates as pertaining to mental health services is the matter of how they view or define mental health. For many Indian elders, the ultimate in mental well-being is to be fully compliant with their own religious beliefs and traditions, and to live "in harmony with nature." This pre-disposition on their part to adapt to their environment may also lead them to accept it as their lot in life; therefore, they do not seek to change the circumstances, and they do not seek help to bring about any improvements until there is some contact or intervention initiated from an outside source (a family member, social worker, or other service provider).

If, then, we are conscientious and compassionate advocates and service providers, we must seek ways in which to enhance that environment to which the elders believe they must adapt themselves. We must teach young people, communities, and service providers as well, to "respect their elders." We must take the initiative to build around these elders a truly caring society. How can this be done? And, given the many barriers to access and utilization, what approaches can be used to address this very complex problem? Here are a few recommendations:

1) Legislation is needed which would authorize funds to support a nationwide comprehensive study, perhaps co-sponsored by the National Institute of Mental Health, the Administration on Aging, and the Indian Health Service, to assess both the status of Indian elderly mental health, and their methods of coping with their environment. Included in the study should be a thorough discussion of the elements which are found to be essential to maintaining elders in meaningful roles in their families and communities, and the various essential components of a community-based service delivery system which will contribute to an environment which protects their mental well-being and enhances their quality of life.

2) Legislation is needed which will provide funding for model projects and dissemination of information on the mental health services approaches which are most appropriate for Indian communities -- ideally, these model projects would be developed and conducted by Indian research and program development organizations which would, presumably, have a

better ability to interpret data which is culturally-determined or culturally-based.

3) Mental health and social service workers should be required to conduct outreach efforts in Indian communities to identify at risk elders, and to develop treatment/intervention plans for them (based on the assumption that facility-based intake approaches have not been sufficient to assure the appropriate utilization levels by Indian elders).

4) Paraprofessional service providers such as Community Health Representatives, Home Health Aides, and homemaker service providers should be trained (via resources made available through special appropriations) to detect and report signs of developing mental health problems in Indian elders whom they contact in the course of their daily home visits.

5) In coordination with number 3 above, multi-disciplinary teams should be formed through collaborative efforts of the Indian Health Service, Bureau of Indian Affairs, and various tribal service programs to develop comprehensive case management systems and treatment plans for at risk elders in Indian communities or rural areas. Again, legislation authorizing funding to support implementation of these case management systems is needed.

6) Funds should be made available to permit tribes or Indian health facilities to hire and train patient advocates to act as special interpreters and ombudsmen for Indian elders in need of services (including mental health and social services).

7) The Indian Health Service should be required to establish an area of gerontological focus within its service planning and delivery system, and to establish specialized geriatric health care as a budgeted line item at every Indian Health Service facility, based on the assumption that provision of adequate medical care is conducive to appropriate mental health care for the elders who come to IHS facilities to receive services.

The CHAIRMAN. Thank you, Mr. Cook. The Chair now recognizes Mr. James Berg.

STATEMENT OF JAMES BERG, CHAIRMAN OF THE BOARD, DENVER INDIAN CENTER, DENVER, CO

Mr. BERG. Thank you, sir. Mr. Chairman, Congressman Bilbray, I appreciate the opportunity to be here this morning and to speak on behalf of the consumer to the panel here, and for specifically my mother as a family member.

We have, as American Indians, tried many times to express to different individuals why we are in an urban area. First of all, 60 percent of American Indians in the country today, live in urban areas.

As such, people do not realize why we are here. I have tried many times to draw analogies on why American Indians move to the urban areas, but so many times they do not work.

So, I am going to try something a little different this time, and it may be humorous, but I hope that it will make a point and that point is American Indians are here in the urban areas for very specific purposes.

I will draw an analogy with that of Dorothy and Toto in the Wizard of Oz. They had a conflict and that conflict was in the form of limited opportunities. So, in trying to resolve that conflict, they thought that they would follow the yellow brick road and find some additional opportunities, a deeper meaning for their lives. American Indians, in comparison, on the reservation areas, have conflicts as well.

Those conflicts are a high rate of unemployment. A rate of 78 percent. Economic underdevelopment, poverty and deplorable conditions that drive American Indians to the cities to seek better opportunities for themselves and their families.

That is why my mother is here. That is why she has been here for the past 30 years, but, the difference is, in the Wizard of Oz, Dorothy and Toto could go back, but things have not changed in reservation areas, and, so, American Indians, they do not have that same opportunity.

They have to stay here in the city, in the urban areas, and try to work out something that will give them that benefit to provide deeper and more meaningful lifestyles or alternatives to life for them in this country, and we have not been able to do that up to this point, but we are making headway, and that is why I appreciate this opportunity to speak.

I would like to say that members of the Denver Indian Center staff have determined that there are approximately 400 American Indian elderly in this area alone. Out of those 400 Indian people, elderly Indian people, we have many of them who live in extended family situations. They are living with their sons, their daughter, and, as such, they have conflicts within that area as well.

Sometimes they cannot reach food stamp opportunities or other opportunities because of the regulations that govern these programs and eliminate them from being eligible.

The elders have some problems. Their number one problem is expressed to me as to be transportation. Elderly American Indian

people in the Denver Indian Center area, do not have transportation capabilities. As such, they have a hard time. Even a six-pack of Coke becomes very valuable to them because it may be difficult for them to carry. They may be arthritic and through that arthritic conditions, they have a terrible time with that.

Education. Our Denver public school system has not provided very many American Indian families with the quality education that they need here. This is the first time that the Denver public schools ever had an American Indian Educational Advisory Council, and in terms of employment, the Denver public school and the Denver area, collectively, do not provide American Indians with employment opportunities.

The U.S. Postal Service does not have adequate equal employment opportunities for American Indians. Out of two states, Wyoming and Colorado, there are 55 American Indians working for the U.S. Postal Service out of a work force of 9,000. Denver public schools does not even have an American Indian category or goal in their affirmative action plan.

These types of discrimination affects the elderly because they will not have an extended support system from their own family.

The elderly face the difficulties in obtaining housing, even though there should be housing in the urban areas that would provide for American Indian housing, from the HUD, Indian Programs Office, for an urban area.

HUD regulations make it difficult for American Indian elderly to survive in a HUD housing complex. Seniors and disabled persons have to live by themselves. As they live by themselves, they have to be self-supporting, but no family member can go over there and stay for an extended period of time.

So, I would like to say, too, that this is the first time that the Denver Indian Center has had an opportunity to have some support from DRCOG. DRCOG, in the past, I think, is another group that has not given American Indians in the Denver Indian area an opportunity to absorb some of the funds for our senior citizens.

We had to go through a very detailed appeal process and we had to go through very many processes with DRCOG to obtain funding. It seems in the Denver area, that American Indians are very much at the bottom of the concern list, and a lot of times, that is because of our population.

We do not even represent 1 percent of the work force in this area, but that should not matter, but what happens is that Hispanics, Blacks and women seem to have first priority over everything.

All of these situations and interactions focus in and affect the elderly. My mother is an example which I will focus on. She is an alcoholic. She has been an alcoholic for many years, and that has not changed and we all know that is not going to change and we all know the cycle that derives from that.

Through that, she has problems that she needs to deal with. Depression. She has to deal with loneliness. She has to deal with no transportation system. She has to deal with my younger brother, whose name is Kenny. Kenny himself is a victim of mental health problems.

As such, he has depression, too. But as a young man, he goes to my mother as his support system. She does not really have the sup-

port system to support herself, and now she has to take care of my younger brother, and my younger brother is somehow or another relying on her as his support system.

Today, my brother is in the hospital for mental health observation and evaluation. The doctors want family support, and my mother has to be there and the family has to be there, but it is just very difficult. It is very difficult because everybody who is part of this family is trying very much on their own to make the difference, and to become successful.

When I go to my mother's house, she may want certain things done. I think the idea of homemakers coming over to our elders homes and helping them with some of their small tasks once in awhile would be beautiful because a lot of times, it is too hard for them.

The doctors may tell them to buy lighter pots and pans because theirs are too heavy for them to move. There is not enough concentration on American Indians, their needs, the elderly, and specifically, the female elderly.

I think we have stated that there is a need for elderly in general, but I think that we need to concentrate on the female elderly because she is the part of our extended family that we look up to the most, and she is the part of the family that brought us into this world and given us our values and carried us through the first years of our lives. They need a support system that I think we can provide.

I would like to say that my mother has experienced, as many other people have as well, separation or a divorce situation, and I was taken away from her when I was 5 years old. But, still, she provided me with the values, and the strength to carry on by inserting into me my personality and my character by the time I was 5 years old, and through that, I am able to sit here today and try to help her out in return, and, so, that is what I have to offer, sir.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Berg.

The Chair recognizes Mr. Fred Acosta.

STATEMENT OF FRED ACOSTA, M.S.W., M.P.A., PROGRAM ADMINISTRATOR, COLORADO DIVISION OF MENTAL HEALTH, COLORADO DEPARTMENT OF INSTITUTIONS, DENVER, CO

Mr. ACOSTA. Good morning, ladies and gentlemen, members of the committee. My name is Fred Acosta. I am a program administrator at the Colorado Division of Mental Health, Colorado Department of Institutions.

I want to thank you for this opportunity to provide testimony to the Select Committee on Aging.

The Colorado Division of Mental Health is a State mental health authority and has the responsibility to provide care and treatment to those individuals most in need. The State mental health system is comprised of 24 community mental health centers and clinics, and two State hospitals. The system employs in excess of 3,300 full-time equivalents and has a total budget from all sources in excess of a $120 million per year.

The Division of Mental Health estimates show that there are 241,700 persons in need of mental health services or 7.4 percent of Colorado's population. Hispanics comprise 11 percent of the total population or 360,000 persons. The elderly comprise 12.6 percent of the population or 413,000 people. Assuming the age demographics for Hispanics parallel those of the State population, it is estimated that there are 45,360 elderly Hispanics living in Colorado. Again, assuming that the Hispanic elderly are in need of mental health services in the same proportion that all elderly, 18.6 percent, it is estimated that there are 8,400 Hispanic elderly in need.

The President's Commission on Prevalence Rates used in Colorado need estimates model may be slightly high for the elderly, and I am referring to the President's Commission on Mental Health Needs that was published in 1977-78. But even if we are to cut our estimates of Hispanic elderly in need by half to 4,200, Colorado only serves 461 persons in the last year or 10.9 percent of the need.

In preparing my comments for today, I began by reviewing those issues which have historically impacted our system's ability to provide quality care and treatment to the Hispanic elderly. At that time, I had not yet received a copy of Congressman Roybal's article from the March 1988 issue of American Psychologist. The issues I identified without exception were referred to in that article. My purpose here today is to reaffirm that, in fact, those issues noted in the article do, indeed, reflect the reality that Hispanic elderly face.

It has long been the position of the Division of Mental Health that the elderly as a group remain underserved and in comparison to their need. The reasons for this are many and varied. However, of all the targeted groups that we have in the system, children, adolescents, adults and elderly, the disparity is most pronounced with regard to the elderly.

Some of the key barriers to the provision of quality mental health services are listed below, and due to the time constraints of this testimony and the complexity of these issues, I will highlight some of the circumstances which will provide the committee a sense of the issues involved.

Number 1. Lack of specific data or research information applicable to State and local areas. The Colorado Division of Mental Health does not have specific data with regard to the mental health needs of the Hispanic elderly for the State.

While the information would be desirable, the resources do not exist to allow a comprehensive study to be undertaken.

Number 2. Access and availability of specialized programs. Public mental health system with rare exception does not have the capacity or the capability to provide this specialized treatment for population groups, such as Hispanic elderly.

This is due in part to the lack of resources, but also due to the fact that the numbers and overall distribution of Hispanic elderly make it difficult to warrant establishment of such programs.

Number 3. Relevant and appropriate services. Hispanic elderly cannot be lumped into homogeneous groups. Their experiences, education, economics, et cetra, are varied and diversified. Their ability to maintain the traditional role within the family also varies. Thus, in any given situation, they will be as heterogeneous

a group as exists in our entire system and no one service delivery model can suffice.

Number 4. Multiple liabilities. The stigma of being mentally ill or an ethnic minority or elderly are well documented. When we combine these circumstances within the same individual, that person's ability to self-disclose is severely impacted.

Added to this situation may be a completely different value system as well as a different language. It is no wonder that the capacity of the system to intervene and treat in these situations is severely limited.

Number 5. Lack of specialized staff. It is only recently that any of the graduate schools which educate and train mental health professionals have developed any type of emphasis with regard to the elderly. While in some instances, there are courses offered emphasizing the ethnic minorities, very rarely are the special needs of the elderly taken into account. Thus, any type of specialized skills required for serving the Hispanic elderly must be obtained in the actual job situation. Because of competing demands, little or no attention is given to this aspect of the service delivery system.

Number 6. Inability to relate to the current system. Hispanic elderly in the State of Colorado for the most part have come from the rural areas of Colorado as well as other rural areas of the Southwest United States. Typically, they have been self-reliant and independent and not involved in the human services delivery system for a multitude of reasons. There is no tradition of seeking assistance when needed and since the majority of Hispanic elderly now live in the urban areas of the State, there is not a tradition of accessing the public sector agencies. All indications point to the fact that this is one of the most difficult populations to involve in on-going treatment intervention.

Next is responsiveness of the system. Due to the lack of resources, specially-skilled professional staff and relevant programs, the mental health system is not viewed as responsive or receptive to the Hispanic elderly.

Fragmentation of the service delivery system. For the most part, the human service agencies throughout the State do not fare any better with regard to services for the Hispanic elderly. Although the numbers of Hispanic elderly continue to increase, to my knowledge, there is not an agency which specializes in service provisions solely for the Hispanic elderly. Thus, the expertise needed to intervene with this population is not being developed and established.

Lack of benefits. Generally speaking, the Hispanic elderly have occupied the lower rungs of the socio-economic ladder. This is due in large part to the lack of educational opportunities as well as lack of employment opportunities. Because of this situation, the Hispanic elderly have had less of an opportunity to acquire and participate in benefits of the job, such as health insurance, sick leave, preventive health care, et cetra.

Hispanic elderly have historically functioned in labor-intensive, physically-dangerous jobs. In many instances, this has led to the onset of physical and emotional difficulties of aging at an earlier chronological age than the general population. Also well-documented is the fact that Hispanics have a shorter life expectancy than

the general population. Because of these factors, there are significant ramifications for providers of mental health services.

The family is the primary care-giver. Traditionally, the adult children of the elderly have been viewed as the primary care-givers. This is no longer the situation. With the majority of Hispanics living in urban areas and the need for both adults to be employed, the availability of the family to care for their elderly has been severely eroded. The corresponding alternatives for care of the Hispanic elderly have not been developed, and the problem continues to grow in magnitude.

Treatment outcomes. Traditionally, models of treatment outcome do not lend themselves to the Hispanic elderly. To my knowledge, there does not exist a viable approach which can be applied in the case of Hispanic elderly. There is great need for further research in this area if the mental health systems are to positively impact the needs of the Hispanic elderly.

As you can see, many of these problems are of a long-standing nature, and it will take the resources of the Federal and State governments over a long period of time to make a positive impact.

In reviewing the article by Congressman Roybal, one cannot argue with the proposed initiative to deal with mental health needs of the elderly. This initiative is a comprehensive well-designed and logical approach to many of the issues which prevent adequate care and mental health treatment of the Hispanic elderly.

The Colorado Division of Mental Health would support such an initiative.

I wanted to make four general recommendations in terms of services for Hispanic elderly. They are as follows: enhancement of traditional treatment modalities to respond to the needs of the Hispanic elderly. Targeted research with regard to the needs of the Hispanic elderly and effective interventions.

Increased training and education for bilingual, bicultural individuals who will be employed as mental health professionals in the mental health systems.

And, lastly, streamlining of the Federal entitlement programs which would eliminate barriers to services for the Hispanic elderly.

Once again, I would like to thank the Select Committee on Aging for the opportunity to provide testimony, and I will make myself available at the appropriate time to answer any questions.

Thank you.

The CHAIRMAN. Thank you, Mr. Acosta.

Would you also make available to the committee the recommendations, the last recommendations, you have made? I do not see them in your written text.

Mr. ACOSTA. Yes, I will do that.

The CHAIRMAN. Thank you.

The Chair now recognizes Jose Mondragon.

STATEMENT OF JOSE MONDRAGON, M.S.W., SERVICIOS DE LA RAZA, DENVER, COLORADO

Mr. MONDRAGON. Thank you, Mr. Chairman, Mr. Bilbray, fellow panelists, members of the audience. Let me make a brief statement

before I really get into the nuts and bolts of what I have written down.

I am very pleased, very honored that I was asked to testify before the committee, and I was even more pleased when I was asked to identify consumers of the mental health system to also come and to testify.

I was able to identify a couple of individuals, one in particular who was willing to testify. With all due respect to the process, at the last minute, we had to eliminate the individual because we could not accommodate him because he is monolingual Spanish-speaking, which is one of the major obstacles that we face not only in hearings such as this, but in our mental health system in general.

As I prepared to testify before the Committee on Aging, Mental Health, specifically with regard to Hispanic elderly, I stopped to think through the 20 years plus that I have worked in the mental health field.

During those years, I went from a trainee position at a State hospital to my current position as Executive Director of Servicios de la Raza, a specialty clinic, addressing the needs of Hispanics in the Denver metropolitan area.

The question surfaced for me was how much have we advanced in those 20 years that I provided mental health care for the Hispanic population and specifically the Hispanic elderly. I revisited some of the textbooks that I went through in the process of educating myself and, in particular, a textbook on abnormal psychology, looking at the section on the aged. It was very interesting to revisit in that it was entitled, "Aging and Death". Catchy title.

The chapter started as follows: "The mental health of the aged is not yet a well-developed area of scientific and professional consideration. Traditionally, research efforts and professional services have focused on children and young adults, but little of this information can be applied to the psychological aspects of aging."

I visited a monograph entitled, "Chicano Aging and Mental Health". In the monograph, in the section entitled Foreword, it begins, "Research in aging is a relatively new area of focus for the National Institute of Mental Health. With the establishment of the Center for Studies of Mental Health and Aging, the Institute has made a major commitment to advances in research, education and services in the field of aging.

Ten years of time elapsed between the aforementioned examples, the theme is the same, a commitment or admission to the lack of or a plan to conduct research on the mental health of aging Hispanic elderly, et cetera

The following example of what Hispanic elderly must actually face in the process of trying to obtain mental health services, I think, is a classic example of how far we have actually come.

About 1 year ago, while working as a discharge planner on a psychiatric unit, I had the opportunity of working with the following individual. Antonio was a 70-year-old Hispano who was taken to a detention center by police, booked, and charged with a misdemeanor crime and placed in the custody of the jail psychiatric services team due to inappropriate behavior.

While housed in the psychiatric unit, Antonio was evaluated by a psychiatrist and determined to be suffering from bipolar manic depressive illness and alcoholism. He had a 50-year history of using alcohol on a daily basis. It was recommended that Antonio be transferred to a local mental health center as they felt that jail was no place for an elderly person such as Antonio. He was sent to the hospital psychiatric unit for further evaluation and treatment.

A quick social history revealed that Antonio was unemployed, living alone, had been divorced for a number of years, had two children who do not visit him due to his alcohol-related behaviors. This elderly gentleman rented a small one-room house, he received a small pension from Social Security and his days were spent drinking with the crowd.

An in-depth evaluation was done by a psychiatrist, and the psychiatric staff of the gero-psychiatric unit, who agreed with the initial diagnosis of manic depressive bipolar illness and alcohol addiction. Antonio was started on a small amount of lithium and seemed to respond quite well.

Much of the "inappropriate behavior" which the patient demonstrated earlier was brought under control. The discharge planning process, as the system dictates, starts when someone is admitted. Discharge planning for Antonio included a 30 to 45 day stay in an alcohol treatment program, a private facility, very nice. They agreed to accept Antonio despite the fact that he was low-income, probably because of his Medicaid-Medicare eligibility, and the fact that through that process, he could actually afford their fees.

It was expected that upon completion of the 30 to 45 day substance abuse program, Antonio would be followed on an out-patient basis, be enrolled in a daycare program for seniors 3 days a week, and provided monthly follow-up visits by a social worker.

A week to 10 days into his stay in the substance abuse program, the discharge planner from the program called requesting the plan we had for Antonio's discharge once he was released from their program. There was the initial indication that Antonio was not working well in the program.

A few days later, Antonio was returned to the gero-psychiatric unit of the Community Mental Health Center Hospital Division. He was unable to stand, unable to walk. He was brought in a wheelchair hunched over so that his head was barely off of his knees. He was having considerable difficulty staying conscious and clearly did not know where he was or who he was.

Upon extensive medical examination, it was determined that Antonio had apparently received an excess amount of lithium. His feet were severely swollen. They looked like balloons. He remained semi-conscious for several days, unable to communicate. Once Antonio was nursed back to health and able to communicate, he recounted his story of his experience in the alcohol treatment program.

Apparently he understood very little of what was expected of him in that program. Despite the program's claim to having a bilingual Spanish-English staff, no one but the cleaning lady spoke Spanish.

When it was music therapy time, Antonio rose to the occasion but refused to sit and listen to Beethoven and insisted on dancing

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with the women in the group. He was reported by the staff indicating that Antonio was demonstrating manic behaviors, and subsequently he was medicated.

Antonio was eventually discharged from the gero-psychiatric unit not to a nursing home because he elected not to go there, he elected to go home, to the barrio, to rent a two-room house. Antonio resumed treatment, not with a mental health program but with a senior citizens program where he goes to a daycare program three times a week.

He is learning to socialize without the use of alcohol, as he still expresses fear of being placed back in a program for alcoholics. How far have we come during the 20 years of my experience in the mental health field? Not too far.

There is clearly a need for outreach workers who know the people, who can speak the language, and who have skills to identify those truly in need of mental health care.

Bilingual, bicultural staff in existing programs who clearly understand the culture and can communicate with the clients who are referred for services, staff able to understand the dynamics between technical intervention and those cultural variables as they intervene in that process.

We need research that bridges the gap between researcher and practitioner so that we can develop treatment methodology that is relevant for Hispanics. We need to advocate for governmental policy which makes it possible to institutionalize fairness, to develop standards that mandate that quality mental health care be delivered to our Hispanic elderly.

I thank you.

The CHAIRMAN. Thank you, Mr. Mondragon.

I will start out the questioning and then make time available for additional comments, if the members of the panel have such comments to make.

Dr. Manson, the case history that you outlined in your testimony was quite moving. Is it your belief that most American Indian elderly would prefer physical and mental health services in their home setting as opposed to having to visit a community center?

Dr. MANSON. That is perhaps one of the most consistent findings of all of our work, and perhaps which distinguishes the conditions surrounding the wishes of both the Indian and Native elderly themselves and their family members in regards to all other populations, with perhaps the possible exception of Hispanic elderly.

As opposed to the general movement over the last several decades to warehouse our elderly, they, in the Indian and Native communities, are seen as a bridge, the continuity between past and present, and through whom other people can project what their futures will be like.

The case that I described is not atypical. I think one is constantly amazed at the extent to which there is effort at considerable personal cost to retain our elders living in independent living situations and, in fact, the families themselves are designed to promote that.

The problem is, as all of our studies indicate, that despite the availability of that kind of supportive care and nurturing on the

part of family members, those resources are still in and of themselves inadequate to meet the demand.

The CHAIRMAN. Well, the reason I asked that question is that I have had experience along those lines. Before I became a politician, I was doing community health work. I was in charge of the First X-Ray Mobile Unit that was put out in this Nation back in 1940.

I was involved in the field of tuberculosis control, and at that particular time, very little work was done among minority groups. In fact, practically no work was done.

So, I would go into the minority group communities and prepare that community for a visit that was to take place 2 or 3 weeks later. This was the chest x-ray mobile unit that would come in and take chest x-rays.

At the very beginning, we were very unsuccessful. People did not respond. Well, we finally were able to get the response that we wanted no matter where we went, by involving the community leaders in the process.

When the professional goes to a community, we found out, and offers a program to that community, there was very little response, but if we reversed the process and went to that community with the information that such a program was available, and that we would make services available if the community was interested, we got a very different response.

Community leaders did not want to be left out, and they decided that they would sponsor such a program,and before you knew it, the community was involved and getting more people there than we could take care of in 1 day.

We delivered the service to the community. I asked that question of Dr. Manson and I ask the same question of Mr. Acosta.

In the Hispanic community, would the delivery of a system to the community itself be more profitable insofar as direct servicing is concerned?

Mr. ACOSTA. I would have to say yes. One of my roles at the Division of Mental Health is the Medicaid program manager, and if you look at the way that our Federal entitlement programs are constructed, they are based on the medical model with services being delivered in a "health care facility". That is not what our elderly need.

Our elderly need community-based services. They need home services and given the construction design of our service delivery systems, this is not possible.

Within the last couple of years, at the Division of Mental Health, we had a home and community-based waiver under the auspices of Health Care Finance Administration. It proved to be very effective in terms of quality of services delivered, cost effectiveness, and as well as the number of individuals that we took out of more intensive settings, in this case nursing homes, and put back in to the community.

At the end of that 3-year period, HCFA reviewed our application or our reapplication to continue the waiver, and basically they denied us. They denied us on the basis of policy regulations that we could not live up to. They did not deny us on the basis of quality of services, number of people served, or cost effectiveness, and that is in writing.

This particular waiver dealt with the general population. It was not designed for elderly or Hispanics in this particular case. But it is a demonstration of how locked in we are into a system that no longer is responsive to the needs of groups such as this, and I think as a State bureaucrat, one of my jobs is to fence with the Federal bureaucrats.

We lose it. I think sometimes we forget what we are about and what we are supposed to be doing for the population in need, and one of my recommendations in a general way is we really need to look at the barriers inherent in, for example, Federal entitlement programs that are passed on to the State.

It is not a good way of doing business of providing services, and, quite frankly, I do not think anything is going to change getting Hispanic elderly into our health care facilities unless those changes come about. It is not going to happen.

The CHAIRMAN. I will ask the same question of the other panelists as to, first of all, a method that can be used to form a policy that is not just national, in name only, but includes significant input from all of the States. I mention this because Congress occasionally declares something as being national in nature without talking to any of the key participants in the 50 States of the Union.

My question is, how can we develop such a program that will ultimately become a national plan? Remember that question because I want to bring something else in, and that is that we thought that when we had the White House Conference on Aging, that we would have the opportunity to develop that particular concept.

The truth of the matter is, that we have had two White House Conferences on Aging, at least since I have been in Congress, and nothing has come out of it. Now, maybe you have a solution.

So, let us see if you agree or disagree. Dr. Manson, will you start out and briefly tell us what it is that we can do? I know this is a deep subject, but let us find out if we have in mind a proposed solution.

Dr. MANSON. Well, first, in terms of the governmental mechanisms, with Indian and Native people, you have the unique opportunity. You have the Indian Health Service and you have the Bureau of Indian Affairs, that touch all reservation-based community populations.

Secondly, you have Public Law 4-37, Urban Indian Health Care Improvement Act, up for re-examination in 1990.

Both of those or all three of those mechanisms provide direct avenues into both reservation and urban-based communities, and you can dictate a uniform policy with respect to the nature and type of services, mental health oriented, to these populations, and that is probably the quickest route to do it, and it is, I think, open currently for discussion.

The CHAIRMAN. Does any other member of the panel have a suggestion to make with regard to this one question?

Mr. ACOSTA. I think that there needs to be a restructuring of Medicare-Medicaid, and the Federal Block Grant system for mental health. They are very constraining and the reality is that they are seen as funding mechanisms rather than programs of service-type mechanisms, and there needs to be those options included in the

Federal legislation as well as the rules and regulations that govern service delivery.

I think if those areas were explored and viable alternatives developed, that the States and local areas and those of us responsible for care and treatment and overseeing of the systems would be in a position within a matter of months to take advantage of those kinds of opportunities, but right now that does not exist.

Mr. COOK. Mr. Chairman, I would like to just add to what Dr. Manson has said, and tack on a couple of different perspectives, and one of those perspectives is this.

That, yes, we have an existing system. We have an existing mechanism. The Indian Health Service, Bureau of Indian Affairs, and other agencies entrusted with the responsibility to serve Indian people and Indian communities; and one of the problems that we face as advocates is getting these various agencies to live up to that responsibility, and responsiveness is going to have to be something that they acknowledge as a part of their mandate.

The Indian Health Care Improvement Act, for instance, states that Indian people shall receive health care which is equal to or better than that of the general population. That is a promise made by the Federal Government, and, yet, conditions exist among Indian people which are literally atrocious.

Their death rate from tuberculosis, from cirrhosis, from other kinds of illness is exceptionally high, and health care programs in Indian communities which might help with those situations are being targeted consistently by our administration for elimination from the Indian Health Service budget.

The community health representative program, for instance, which is virtually a lifeline to the Indian elderly in their homes—that is the program that visits the elders right in their homes and administers medications, provides transportation to the facilities, and so forth—is a program which has been consistently targeted for elimination.

Those programs must be protected and, in fact, must be enhanced, must be upgraded. I mean by that, that community health representatives, for instance, could be provided training to become certified home health aides. Indian tribes could then establish their own home health agencies and receive Medicaid reimbursements for the services delivered to the people in their homes. This would provide an added means of developing resources for the provision of adequate health care to Indian people.

The CHAIRMAN. I would like to concentrate a bit on the Indian population, and in giving you the other side of the coin, I am giving you some of the arguments that are made in my own Committee on Appropriations.

We just marked up the Health Bill for 1989 yesterday, and I presented an amendment for increasing funding in various Indian categories. The debate resulted in criticism by various members of the committee that existing agencies dealing with Indian matters, particularly the Bureau of Indian Affairs, were ineffective. The person making the major presentation said throwing money at them is not the solution. Now, in my opinion, money is or can provide a solution, providing there is a program attached to it.

Now, you as experts in the field have made reference to the fact that we as a Nation have made promises, and that those promises have been broken. Now, it is very difficult to defend that position when I, for example, did not have the background information to really answer it. What I do know is that there was a lot of truth in what that man was saying.

In your response, Mr. Cook, you said that we must establish home health agencies within the Indian community that would help them help themselves. First of all, I think that the Indian community, and I think it is an excellent idea, have to get together and prepare a program that can be submitted to the Congress of the United States.

How can that be done without having to go through the Bureau of Indian Affairs or any other bureau? How do we get the needed information from the field?

Is that something that can be done?

Mr. COOK. Yes, and it can be done very quickly and aggressively through the collaborative efforts of organizations such as the National Indian Council on Aging, the National Indian Health Board, whose executive director is here, Mr. Jake Whitecrow, in the audience, and a collaborative effort bringing together the leading figures in the fields of mental health, providing of medical health care, and in the provision of services in Indian communities, include the advocates as well, so that we can have that sensitized level of service planning that is really necessary for appropriateness in the Indian community.

We can bring these people together in an interagency/interorganizational/interdisciplinary kind of a panel, to discuss ways and means of getting this done, and to develop specific legislation which would provide that.

We could then present to you draft legislation for your approval, for your modification, and legislation which would then require the kinds of services in Indian communities which are necessary.

The CHAIRMAN. I would like to see, Mr. Cook, a proposal that would outline the plan, and I will make every effort to try to get some kind of funding, I do not know where, but some kind of funding that would match the dollars raised by the local community for a conference of that kind.

Mr. COOK. Thank you.

The CHAIRMAN. This is not a promise, but it is a suggestion that perhaps this is one place where we can work together in starting from the community level to the Congress, instead of going to the Congress through existing organizations that are being criticized. We need to get right down to the grassroots level of the community.

Mr. COOK. Thank you very much. I will give you a promise, and that is that you will see the proposal soon.

The CHAIRMAN. Thank you very much.

Now, Mr. Mondragon and Mr. Acosta, we do not have the Bureau of Hispanic Affairs, but promises to the Hispanic community have likewise been broken as you all know.

Can we in the Hispanic community do something similar? Do you think, first of all, that we should? Give me your general idea with regard to this proposal.

Mr. MONDRAGON. Okay. I do not only think that we can, I also agree that we should, but I think that the problem is much more complex than that in that what we are talking about are various systems interacting in order to accomplish a particular task.

To get to the grassroots people and to have the grassroots people and those leaders develop proposals for programs that might be effective is one minute piece. As you know better than any of us, the political system is a very tricky beast, if you will, in accomplishing what we need to accomplish, and when we get into the whole political arena, there are various subsystems that need to be looked at that directly affect the problem.

And I am speaking specifically of the American Medical Association, the American Psychiatric Association, the American Psychological Association, and all of those groups that promulgate standards for care.

If we do develop programs and do not change those standards that impact how services are delivered, we can be as innovative as we like at the grassroots level and we could have as much dialogue as we would like between the grassroots and Washington, those programs will not work.

Until we institutionalize equality in programs and quality care for those groups, are we going to see programs actually succeed?

The CHAIRMAN. If the present system, Mr. Mondragon, does not work, I would acknowledge that we have to try something else. Actually we have not tried the approach of coming from the grassroots level.

I am a firm believer that the political system and attitudes within the political system will never change unless our constituency demands it. If it does not come from that area, then changes will not be made in any system.

What I am suggesting is whether we should look into a reversal of this procedure?

Mr. MONDRAGON. Absolutely.

The CHAIRMAN. Would it be worth our while to do that? Mr. Acosta, what do you think?

Mr. ACOSTA. A couple of comments. As recently as the beginning of this week, I believe it was Monday or Tuesday, there was a document that came across my desk which I did not have a chance to get into depth, but it was entitled, and I apologize if I do not have the title correct, but it is from an oversight committee of Congress, and it was a report basically entitled something to the effect of failure of Congress to meet the needs of the mentally ill, and in glancing at it, I thought it was a report that basically said that in the big area of mental health, Congress had failed to live up to the laws passed and the expectations generated over the last 20 years when it comes to community mental health.

I think that is real. I think the issues, the political issues, the funding issues, that are prevalent right now have really said to those in need as well as the general public, the Federal Government wants to get out of this business and they are passing it on to the States. I do not think that is any big secret.

I do not believe the states have the capacity, the expertise, the capability of picking up the ball. I think it does take the Federal

Congress and through legislation and funding. I really believe that that is the most essential piece.

I see this as a joint venture, really, with those of us that provide services all the way from the family, from the advocates, to the local service provider to those of us that manage the systems, really having to work in a joint venture, a joint partnership, if you will, to bring about that reality.

I do not know how doable that is in the foreseeable future given the economics and given some other things that I will not go into right now. There is no doubt that that needs to happen. I think we need to work from a number of different perspectives, from a number of different approaches, and personally/professionally and from our organizational standpoint, I think we would like to see something like that happen.

We could support that. We would work towards that goal, towards that end.

The CHAIRMAN. All right. Thank you.

Now, I would like to go into another subject, which is closely related, and that is the matter of attitude.

Mr. Berg, you made mention to the effect that attitude and language would have in the home. Now, do you believe that the Indian elderly avoid mental health services; one, because they do not understand the language; or two, because of the stigma that may be attached to it?

Mr. BERG. Yes, sir, I do, and I might add that in connection with that, recently I represented an Indian elderly person along with one of the members from the Denver Indian Center, who was on the verge of being evicted from her HUD housing unit.

Rather than have the meeting at the manager's office or at HUD or anywhere else, we had it at her house. She felt more comfortable there, and we were successful in having the eviction withdrawn.

I know that they have this uncomfortable feeling, and it is probably one of mistrust. In restaurants people will stare at us, and I know that my mother has often said out loud, "Why are you staring at me?"

So, there are probably more reasons than that, but I really believe that; one, it is a language barrier, and I believe that; two, it is just an uncomfortable feeling of all of these many, many people in an unfamiliar area.

The CHAIRMAN. You know, a very interesting thing happened this morning. I did not expect this question, but the question that was asked of me was along the following lines. Do you think that language barriers are, or can be the result of depression? The questioner went on to ask what effect occurs when the grandparent speaks the language of the culture, whatever that happens to be, and the grandchild speaks only English.

I was not really prepared for such a question, but I think that the man who asked that question was pinpointing a very specific problem in the Hispanic community as far as I am aware and I am sure in the Indian community as well.

Now, Dr. Manson, I think you have the experience and background to answer that question. Does it result in depression? What is the result of that lack of communication on the closeness of the

family, first of all, and its subsequent results insofar as mental health is concerned?

Dr. MANSON. It represents one of the greatest currents of conflict in Indian and Native communities today. We are beginning to recognize intergenerational conflict, and beginning to surface increasingly candid discussion around issues of elder abuse.

What happens is that older adults, older American Indians, Alaska Native people, who have been the repository for values, have been respected, who have been the teachers, are now reliant upon the younger people. In this case, my grandmother, for the most part, is reliant upon 9, 10, 11-year old great grandchildren who may be living in her home as part of the daily care for her. She is 93. And she has to count on these young little persons to answer the phone, to deal with the postal mail man, basically being her contact to the World.

One does not have to think very long and hard about what impact that has on herself esteem, her sense of personal control, her feeling of general worth it presents natural schisms in the very nurturing and supportive family environment that has been part and parcel of how they have dealt with the World.

I think it lies at the heart of a great deal of the stress.

The CHAIRMAN. Is it not also true that there is a large percentage of people who live alone, that they may not in many cases speak English or be very conversant with the English language? Therefore, because of that, they do not take advantage of some of the facilities made available to them. How big a problem is that?

I ask anyone on the panel who may care to respond.

Mr. ACOSTA. I would respond by saying I have a little personal test that I go through, and that is whenever I am at a human service agency, and I am not talking only mental health, I am talking across the board, and it flashes in my mind the minute I enter that location and that is, if I needed this particular service, would I come here. That is my own little test. Are the people friendly? Do they seem to know their business? Do they care about me and my problem, et cetra?

And I apply that across the board, and I try to look at that in perspective of my parents, and I honestly have to say even going back further to my grandparents, who are no longer here, but that creates a real barrier. It is not only a matter of language, it is a feeling of the environment. It is the feeling of the process that takes place there, and I am sure we have all experienced this in our daily lives in different situations, but I think with regard to the elderly, you are not only talking a different language, you are talking a different culture.

In reality, you are talking a different value system, you are talking a whole different experience, and I will use a little example, the first time that I met with my wife's grandparents, who live down in the San Luis Valley, a very rural valley in this State, my experience the other way was they lived in a little town, a little settlement, if you will, called La Florida, and her grandfather was telling me about, you know, raising cattle and cutting the corn and so forth, and I took that all in and I said, "Well, this is about 29 miles from the nearest town", which to this day is only 300 population, I said, "How did you go to work every day?" We just looked at

each other because his work was right there on the farm, the ranch.

I mean, it took me an hour and I kept figuring, well, how did he go to school, how did he go to work, you know, what happens here when it snows. I mean, there is a little dirt road. He told me they lived there from 1912 to 1948. He knew there was a war and there was a depression and so forth, but that did not affect him. It was a whole different life. A whole different value system, a whole different world, and he only moved from there when the Army Corps of Engineers came in and dammed the river and took it for irrigation. He moved to the city.

Those people are still in our cities and still in need of services and still in need of mental health, but it is very difficult to intervene and provide services.

The CHAIRMAN. You know, all this is very interesting, and it takes me back to the time about 2 years ago when we had a hearing on the intergenerational problems. We wanted to find out whether there were any problems with generations, and one of the things that happened was that we were able to get some, what we considered to be, excellent witnesses that were definitely not on our side.

They presented to the committee what they felt was the truth, and they said that the aging population of the United States was taking resources away from them. They felt that while having made a contribution in the past, that the elderly had already received more than their contribution, therefore social security, for an example, would not be there when their time came.

The truth of the matter is that the social security system is in a sounder situation than the Treasury of the United States. We borrow from the social security $37 billion a year, so we can avoid having to go out into the open market to borrow those additional $37 billion.

Once receiving that information, the younger generation felt since they were making that contribution, irrespective of the surplus, that they should be receiving the benefits. Now, what actually surprised me more than anything else was that in discussing the problems of language and its effect on the delivery of services to the minority community, these young people felt that monolingual minorities should learn to speak English since they are in America.

The applause in that room was what surprised me. Now, how would you have at that time handled the situation? What would you have said to those individuals with regard to the response, "you should learn English, and if you do not, you should not be receiving any benefits"?

Mr. COOK. Mr. Chairman, if I may, I would like to respond to that question briefly.

I would say to that person, that perhaps he has forgotten the history of America, a history in which there were over 500 Indian tribes waiting here when his ancestors arrived, and those 500 Indian tribes now speak more than 270 Indian languages; and, so, to reject their ability to speak their own language in this country, America, to reject the right of the first Americans to speak their own language, is to deprive them of an inalienable right.

Now, that may sound like a contradiction of terms, but that is exactly what is happening by these proponents of the speaking English philosophy, and I would say to that person, if he were to go to an Indian village in any one of these locations where they speak these various languages, that he would have to learn very quickly that in order to negotiate, in order to navigate, in order to be a part of the community, he would have to learn to speak that language and he would then begin to sense some of the sting, some of the stigma and some of the discrimination that might exist if we were to force upon our Indian brothers the necessity of speaking the English language.

I say this because of my own personal experience in 16 years at the Zuni Indian Pueblo in New Mexico, my job was to be a linguist, and to do translation of the Bible into the language of the Zuni people. And I found that what the language did for me was that it opened doors because I accepted them for who they were, because the language is very much a part of who we are.

The language my mother taught me is very much a part of who I am, and for anyone to insist that I learn another language is to reject who I am. For me to have insisted that any one of them speak my language, or to insist that they understand the language in which the Bible was already written would have been ridiculous.

It is, I think, a good commentary on the way that we act as advocates, as servants of the people, if we are able to go in and learn their ways, learn their language, and serve them because that is what we are there for.

The CHAIRMAN. Mr. Cook, the reason I asked that question is that I wanted to make this one point, and that is that there are Members of Congress who actually believe that if you do not speak English, you should not be receiving these benefits.

Now, you know, it is a sad commentary to even have to say that, but I sit in this committee where I hear these things and it is done very subtlety, and if you are not really listening, you do not get the drift of what they are saying.

But the end result is that they are taking that position. I also bring that to your attention because this matter of attitude has to start changing, both from the congressional level and from the grassroots level. We have tried it the other way, and it might be a good idea to try it from the grassroots level, which goes back to the original premise that perhaps it is a good idea to start developing such a system.

Anyone else want to add anything at this point? I understand Mr. Berg does.

Mr. BERG. I would like to add onto my comments the following: one, that does not surprise me that people make comments like that because they have been making them for years. America itself was invaded at one time, that was not by Native Americans, that was by Europeans, and at that time, we had attempts similar to what is going on now in terms of English only, and those attempts then was to eradicate American Indians out of America and, so, they had to have some type of support system behind them in which they could do that and feel morally great about it.

One of the reasons that they at that time utilized was that they are doing this in the name of God. And in that respect, they would

feel very comfortable in extending and communicating that back to the European countries that they were from and state they are killing Indians in the name of God because the Indians are beasts and savages.

One of the other reasons that they used at that time in trying to gain dominance over American Indians at that time was to ignore us, pretend we are not there. That happens a lot today as well.

Third, they utilize in order to make their movements upon American Indians at that time, was one that was called evolution, and then, fourth, I think was one called manifest destiny.

So, today, you are very correct, we will say it is a little more softer, it is not as harsh or as apparent, but it is the same attempt to once again eradicate American Indians and other ethnic groups and gain dominance and control over them, and they just are using a different tone and a different style of speech.

The CHAIRMAN. Thank you, Mr. Berg.

The Chair will now recognize Congressman Bilbray for questions.

Mr. BILBRAY. Mine will be very brief because I have a plane to catch this afternoon. I would like to hear the second panel.

Earlier, Dr. Manson, when you were testifying as to a condition on the Navajo Reservation, the one older family, what percentage of the Native American population today lives on the reservation versus what percentage is in the urban environment?

Second is, on the reservation, what percentages live below the poverty level?

Dr. MANSON. According to 1980 Census, approximately 60 percent of the Indian Native population live in urban areas and the corresponding amount in rural or reservation lands. But the difficulty with that has been historically the undercount and the circular migration to and from reservation communities and rural lands to urban areas that makes——

Mr. BILBRAY. What, in your mind, is classified as the Native America? If a gentleman comes in here, as I mentioned to you last night, that, for instance, is one-eighth Sioux, in your mind, that is no longer a Native American, that is a Caucasian, probably, is that correct, or what is the break-up? Where do you break it off?

Dr. MANSON. Well, DHHS did a study that identified nine different definitions which reflected the variety in Indian and Native communities themselves. That is a definition that is left up to the local level for most cases. In other cases, we have definitions imposed upon us by the Bureau of Indian Affairs and, again, another set of definitions imposed upon us by the Indian Health Service, largely for eligibility requirements for service.

From my point of view, it has to do with the extent to which one is an active contributing member to the community in which they are identified. That may be in terms of language. It may be in terms of access and utility of the cultural knowledge and the symbols that are meaningful in that particular community. I think it is highly variable.

Mr. BILBRAY. But for us to target and to help Native Americans, just like Hispanics or any other ethnic group, should we not put some sort of guidelines? I mean, if a tribe allows somebody with one-sixteenth Indian blood to be registered or part of the tribe, and we target our programs towards a certain ethnic group.

Now, the reason I ask that is my son-in-law was born in South Dakota. His parents registered him in a tribe at the time. On his birth certificate, he is listed as a Native American. He is in educational administration in the area he lives and is talking about going to become a principal. He will probably be qualified under a Native American and obviously, to me, an eighth, of course he would probably get mad at me for saying this, does not qualify him to fall into those categories. That is taking away from the category we really want to earmark. If you are a sixteenth, my grandchild is a sixteenth Sioux, and I certainly do not consider that she should get the benefits if there is affirmative action in certain areas of being allowed to take somebody else's position because she is a Native American.

Now, somebody else would disagree with me on that.

Mr. BERG. We deal with this situation here in Denver quite often. We utilize the definition of American Indian over here because if we do not, and we certify or we serve individuals who are not classified or certified as American Indians, then we end up paying back through a cost disallowance.

So, I myself do not have any problem with somebody being one-sixteenth Indian or one-eighth Indian or one-quarter Indian. What I would like to see is to have some type of rules and regulations that say if you are tribally certified, recognized and can show documented proof through that, either through tribal enrollment or certification.

If we do not utilize something like that then everybody in this room has a great-grandmother who was a Cherokee princess, and that is mathematically impossible.

But that is what happens, and, so, a lot of times, when we are dealing with this and affirmative action here in the Denver area, American Indians lose opportunities by nonIndians individuals having an opportunity to mark the I am an American Indian just because I feel like marking that and because I think that my great-grandmother was a Cherokee princess, and I think by perhaps marking that box off, I will have a better job opportunity or an opportunity through this company to become an employable resource.

Mr. BILBRAY. But, again, let me understand what you just said. If the tribe, say the Seneca decides that they will certify or register into the tribe anybody that is one-sixteenth Seneca, but, yet, the Sioux says it has to be one-fourth, now, theoretically, you could have a lot of young men and women in the Seneca Nation that go to school in New York, get their degrees in education or other areas, and spread out throughout the country and take a lot of positions under affirmative action that maybe they should not be taking.

Should there not be some sort of uniformity between the tribes in the sense of who is registered at what level?

Dr. MANSON. No, I do not believe so. I think that is an issue reflecting local sovereignty, and how nations such as these define the nature of the citizenry. In addition, it is a little moot because, for the most part, the affirmative action efforts in this university and state, we have vast underemployment, underrepresentation of Indian and Native people in all sectors. It is not that we have a surplus of eligible applicants.

Mr. BILBRAY. So, you are saying you would be welcome to take the one-eighteenth Sioux in your university?

Dr. MANSON. If that individual was certified by his or her tribe, and accorded that status, I would welcome them.

Mr. BILBRAY. Good. You know, when you talked about the American language and the English language being used, you know, as the sole language, I have not seen what Congressman Roybal has seen in the sense of I have not been on the committee very long and have not heard the innuendoes.

I think the problem that I hear is the fact that there is a general fear among some Members of Congress that they do not want to see a Canadian-type of situation in the United States or certainly like you see in the Soviet Union where you have maybe 20 or 30 different languages being used throughout the country. They want one central language portrayed, business, commerce, just like in India, where English is actually not the official language of India, I do not believe, but the fact is if you want to function in India, you have to know English, and because there are so many dialects and so many different languages in that country.

I think that is the fear that many Members of Congress have, and I hear this expressed. The fact is that when you were talking about the story about the grandmother and the grandchild. I remember my mother talking about her grandmother who spoke nothing but German, and my mother never spoke German but she understood what my grandmother, her grandmother was saying. She would say go get some water, whatever it was, she understood it and, but yet, could never speak the language directly to her grandmother.

So, I am sure that every generation has had this problem, and I can understand especially in the Native American culture, there is more of a high profile to retain the Zuni language, the Navajo language, the Apache, the Sioux, the Choctaw, Chippewa.

Mr. ACOSTA. I would like to comment on that, simply because in another realm, we have an initiative right now in the State of Colorado for an English-only piece of legislation, and very briefly, I think the biggest problem with that is enacting and legislating, you know, "free country". What the official language should be, and I have heard all the arguments on the side of the Montreal situation and those bad examples.

They are attributing a lot of other problems to English language problem. I have yet to hear people going, I had an opportunity last month to visit some places in this country that I had not been to previously, San Antonio, Texas, a good example of a multi-lingual, multi-cultural city, where the free marketplace has been determined.

I was a little bit shocked to see so many "Anglos" speaking Spanish. That is beautiful. That is great. I was just down in New Orleans at a meeting where Manuel was at, and to see the mixture of the cultures and the language down there is beautiful between the Black and the Creole and so forth.

Those are the models that we ought to look at, not the Montreals, where it is politically and otherwise motivated. If we go to certain parts of this country, and I am glad to say perhaps more in the Southwest, I am going to be spending the Memorial Day week-

end in the Santa Fe, that is a beautiful part of the country culturally and otherwise. That is not to say there are not problems and there are not a multitude of things that need to be addressed, but to see a blending of the cultures and the language, it is absolutely, I think, what this country was supposed to be about.

And if we let ourselves go back to this only or that only, I think we are playing right into the hands that will eventually pull this country apart, and I mean that sincerely, and you can look at it historically in Europe or Asia or wherever you wanted to. We should be above that and if we fall into that trap, I have real serious reservations about the long-term establishment of what we stand for in this country, and that is my——

Mr. BILBRAY. So, you are saying the Indians have reservations, too.

Mr. BERG. I would like to make a comment, too, please, if I may.

The CHAIRMAN. If you could make it brief, we would like to get to the other panel.

Mr. BERG. First of all, consider the Self Determination Act on American Indians. This would effect our self determination. Second, consider the Religious Freedom Act on American Indians as well, it is important, very important to know that to be a medicine man you have to have an understanding of your traditional language.

The CHAIRMAN. Thank you.

Ladies and gentlemen, Congresswoman Schroeder, I would like to welcome you, Pat, to the committee.

We will proceed now with the Panel Number 2, and we will ask them to come forward. Dr. Baler, Ms. Gallegos, and Molly Snyder.

The Chair will recognize Dr. Baler first.

STATEMENT OF PRISCILLA GALLEGOS, ACTING DIRECTOR, DIVISION OF MENTAL HEALTH, DENVER, CO

Ms. GALLEGOS. Good morning. First of all, I would like to compliment the gentlemen who preceded us on this panel because they presented some very important and on-going issues.

If you would have had 100 people here presenting issues, it would have been a repetition of some of the issues that they addressed.

I applaud Congressman Roybal, Chairman of this committee, who plans to introduce very soon the Elderly Mental Health Services Development and Reform Act, which provides for more and better community-based mental health services to the elderly population, and an improved reimbursement method for these services.

America is growing older and this growth is occurring at a very rapid pace. Is the mental health system prepared to meet the mental health needs of the elderly population? I do not think so.

Traditionally, mental health services for the elderly and more specifically for the Hispanic and American Indian elderly have been meager, to say the least, and have not been readily available and accessible, nor culturally or ethnically relevant to that population.

The elderly, have been a silent group, silenced through social and cultural values, through tradition, through the stigma surrounding mental illness, and a fatalistic yet dignified acceptance

echoed by, "the Lord has provided this and this is what we will accept".

Identifying the mental health needs of the Hispanic and American Indian elderly is but a small step in the mental health planning process. Finding the resources required to meet those needs is a monumental task. Both in terms of financial impact and equally important the design and implementation of clinically and cultural relevant services and which are readily available and accessible community-based services.

This process would require funding for research, education, clinically-trained professionals across the board, M.D.s, psychiatrists, psychologists, social workers, nurses, case managers, bilingual and bicultural staff, specialized programs and services to reach the elderly, outreach services versus office modalities, changing attitudes of mental health professional staff toward the elderly, more and better benefits under third party reimbursement mechanisms, program evaluation and treatment outcome studies.

The mental health system is over-burdened with demands to serve special target populations. The elderly, children and adolescents, minorities, the chronic mentally ill, and the homeless chronic mentally ill. Housing and vocational rehab needs of the chronic mentally ill, the dangerous mentally ill population, and on and on.

The mental health system is forced to change priorities depending on the local, State and national focus. Depending on allocation and/or reallocation of dollars. Depending on the needs as expressed by a local, State and nationally-growing advocacy and consumer movement.

Realistically, the mental health resources available to us at this time cannot and will not provide for the fast-growing needs of the mentally ill, much less the elderly, and even less to provide for the unique mental health needs of the Hispanic and American Indian elderly.

We cannot continue to provide mental health services in a rob Peter to pay Paul fashion. So, the Colorado Division of Mental Health, the Department of Institutions, strongly endorses Congressman Roybal's initiative.

The CHAIRMAN. Thank you, Ms. Gallegos.

Will you also submit to the committee the recommendation that you have made? Will you please submit them in writing?

Ms. GALLEGOS. Yes, sir.

The CHAIRMAN. The Chair recognizes Dr. Baler.

STATEMENT OF SHEILA G. BALER, PH.D., M.P.H., EXECUTIVE DIRECTOR, MENTAL HEALTH CORPORATION OF DENVER, DENVER, CO

Dr. BALER. Thank you.

Again, I would like to add my thanks to those of both this panel and the previous panel for the opportunity not only to speak here, which I think is very important, but also to, as a result of having to speak here, to spend a considerable amount of time trying to think about the issues and again this morning starting to talk to people about the issues and again I applaud the specific legislation which I hope eventually will come out of these hearings.

But the ability to in very—easy casual but very important way start to organize local communities, I think, is equally important.

First, I am the Director of something new in Denver, which is called the Mental Health Corporation of Denver. I am new to Denver, I am new to Colorado, but I have spent my last 25 years of professional life in community mental health, trying to provide mental health programs in a great variety of communities, from minority communities through to fairly affluent ones.

So, when I came to Colorado, I found a State and a city, Denver, which are really fairly typical of what is going on in mental health in the country.

In Colorado the community mental health system will be entering its third or perhaps fourth—depending upon how you count these things—year of level funding, and, indeed, I believe that Division of Mental Health's budget is some $30,000 less this coming year than it was last year. So that, overall, there have been years of level funding for various programs.

This is not expected to change in the near future. So, we in the mental health and human services field, therefore, have to look at what our funding goes to and look at it very, very carefully.

There are in this State priorities for services to the mentally ill. Those are not much different from other States. The priority population for the last several years has been the chronically mentally ill, and still continues to be the chronically mentally ill, particularly certain kinds of most in need populations of the chronically mentally ill, those who end up in jails, shelters, and the homeless.

Again, this is somewhat different from the experience I had at the beginning of the community mental health movement in which there was, indeed, a great interest in the chronically mentally ill, but at its best, certainly, there was, indeed, a great outreach orientation and mentality, very much based on an old settlement house model. Mental health centers, indeed, were multi-service centers with lots of outreach into various kinds and parts of the community, including the elderly, including minority populations, youth and mentally ill diagnosed individuals.

In Denver, there are four geographically-based community health centers. It is clear to me that some of the rigidities with which community mental health was carried out never have fit in urban areas.

So, we have to do something about that and we have to do something about that at a local level.

In addition to the community mental health centers, there are two specialty clinics, Servicios de la Raza, Mr. Mondragon you met at the last panel, and the Asian Pacific Development Center. There is also a Denver General Hospital which provides emergency services and in-patient services.

On the local level, through the Robert Wood Johnson Foundation and a grant for the chronically mentally ill, specifically designed for urban areas, we are looking to redesign the mental health service system here, to break down geographic barriers, other kinds of barriers, that exist to service.

We are going to institute city-wide clinical standards and accountability. One of the very important groups that has been looking at our service system is a group looking specifically at various

kinds of special populations. That includes the elderly and minorities as well as minority elderly.

Unfortunately, we are doing this with our current budget. Luckily, we have specialists and experts in some of the programs. Now, our purpose will be to try and move some of that expertise across the historic boundaries that have existed by a training and consultation model that we will develop ourselves and do ourselves as much as possible to try and provide fairness in the system.

As you can imagine, this involves breaking down many historic political intracity turf battles, but we will do it.

It is my view that as we look at services to the elderly and to minority elderly, in particular, we need services which are two ends of the technological spectrum. I have been very fortunate that the former organization with which I was associated had a very large elderly mental health program providing several thousand hours of service per month, most unusual for a comprehensive mental health organization. I think services are needed that are both very high-touch and very high-tech.

We have talked about the high-touch ones earlier and I would like to reemphasize those. In a very outreach-oriented fashion people who are able to make it easier for people to come into the service system or to bring the service system to the clients.

I would like to very much reinforce the issues of the importance of being able to have a cadre of staff whose value system involves going out to people in need and whose background, both human, experiential and professional, can prepare them for that.

At the same time, with the elderly, I feel very strongly that we need some extremely well-trained medically-oriented neuro-psychologists, psychiatrists, and neurologists who to be available to provide services to this population.

It does no good to send a person in, for example, to a nursing home to make some kind of diagnosis of an elderly person based on an interview alone. You need some technical tools, medical tests, and some neuro-psychological tests. These can be done on an outpatient basis, but the high-tech diagnostic assessment in determining the mental health status of the elderly, is as important, I believe, in good treatment planning as is the ability to set up a system in which that person feels comfortable receiving services.

We in Denver are going to try to do our best to use the resources that we have to spread our expertise as much as possible. We will break down our administrative barriers to service. We are going to do all that at a local level, but we need things from you.

We need changes in the reimbursement system for both Medicaid and Medicare to allow us to be able to do this more easily. That is extremely important. We need the ability as the service community to influence the kinds of training support you give to training institutions.

At the Robert Wood Johnson annual meeting for the nine cities involved in the chronically mentally ill project, we recognized we are providing outreach and mobile services as a major part of that program, and we have great difficulties in finding qualified staff.

We need to be able to influence the training institutions to be able to have their students provide the kinds of services which are needed to provide good outreach to a great variety of populations,

and we need to break down somehow what the old ideas of what a "professional" role involves.

We also need your continuing support on the Federal level for training in mental health both in the generic sense and for various kinds of specialty populations. We need that desperately. Federal training funds keep getting cut over and over.

We also need the ability to carry out various kinds of demonstration programs for elderly citizens so that we can combine the high-touch and the high-tech in an integrated way to provide accessible and competent services. Thank you.

The CHAIRMAN. Thank you, Dr. Baler.

The Chair recognizes Ms. Snyder.

STATEMENT OF MOLLY SNYDER, ASSISTANT DIRECTOR, AREA AGENCY ON AGING, DENVER REGIONAL COUNCIL OF GOVERNMENTS, DENVER, CO

Ms. SNYDER. Thank you. Good morning, Congressman Roybal, Congresswoman Schroeder.

My name is Molly Snyder, and I am the Assistant Director of the Aging Services Division at the Denver Regional Council of Governments. We are locally referred to as DRCOG. We are the designated Area Agency on Aging, and our service area covers the eight-county Denver Metropolitan area. This region is home to 53 percent of Colorado's elderly population and 52 percent of Colorado's minority population.

As the Area Agency on Aging, DRCOG conducts needs assessments, funds for direct services, including outreach, and some mental health counseling services. We have funded peer counseling programs for senior centers and have found them to be very effective. We have funded mental health programs for older minorities. The Area Agency on Aging administers a number of direct service programs, including an older worker employment program, and a long-term care ombudsman program.

Our staff provides direct counseling and training to unemployed older workers. Clients who need more extensive mental health counseling are referred to our mental health centers. Frequently, referrals for nursing home clients are made by the DRCOG long-term care ombudsman program. Area Agency on Aging staff have been trained by mental health staff to deal with the anger, frustration and even threats of suicide by older clients. Providers funded by our agency have been trained in dealing with difficult clients.

In the past year, we have cosponsored training for over 200 professional workers on identifying Alzheimer's disease and on behavioral management of Alzheimer's clients. Although we are very proud of our efforts to improve the mental health services for older adults, we believe we have barely touched the surface, particularly in the area of mental health services for older minorities.

Traditionally, older persons have not been frequent users of public mental health programs. However, older adults need many of the same mental health services as the generalized population, plus specialized services including psycho-geriatric assessments, outreach programs, crisis management, daycare, case management, social support services, and family counseling. Educational pro-

grams are needed for staff in nursing homes, alternative care facilities and other service agencies. At the local level, we work with community mental health centers to try to coordinate mental health services for older adults.

Over the past 3 years, our local public hearings have stressed the need for expansion and development of appropriate mental health services for older persons. Three major areas were advocated. Preventive services, active treatment, and mental health services for long-term care residents. Those older persons in adult daycare programs and nursing homes were identified as being very much in need of mental health programs. In four of the eight counties in our region, community mental health centers, in conjunction with senior centers, have developed specialized peer support groups, supervised by mental health personnel, to address mental health concerns of older persons. These services have been particularly successful and program expansion in this area should be supported.

Two problems identified in the DRCOG needs assessment relate to the mental health needs of the regional population: emotional problems and dependency difficulties. Of the total surveyed 10.2 percent of respondents cited specific emotional difficulties, such as loneliness or despair, frequently arising from the loss of a spouse or other family member. These problems were often described in terms of isolation and a sense of abandonment by family and society. Some of the problems also arose from being isolated by inclement weather, and from unhappiness with general external conditions, such as the economy, government or world affairs. Women, persons residing in nursing homes, and those living alone reported more emotional difficulties. Families were used more frequently as a source of assistance with emotional problems. Of the DRCOG-funded programs, senior centers were the only programs identified as assisting with emotional problems.

The second highest category of problems identified by needs assessment respondents involved dependency issues. While these are not necessarily related to mental health issues, they were identified in situations which caused considerable stress for the individual and family, and for this reason, we include them. Nearly 14 percent of the problems reported involved taking care of other family members, being forced to live with other family members, or loss of the ability to take care of themselves. The majority of dependency problems, 64 percent, involved having to take care of elderly parents, spouses, widowed daughters, deserted grandchildren, or other family members.

Over one-fourth of problems reported were associated with the inability to care for self, being forced to rely on others and unpleasant feelings usually of guilt. The remaining 8 percent were other problems related to dependency. Women, persons not living alone, working, in the age group of 60 to 74, were most likely to report dependency problems. Persons who frequently reported dependency problems also included nursing home residents. Family, followed by friends and health professionals, were most often used for assistance with those problems. Of our funded programs, persons utilized the Visiting Nurse Association most often for dependency-related difficulties.

When compared to regional trends, minority persons aged 60 and over report more financial problems and more health problems. Emotional problems of minority older adults are cited in our needs assessment with approximately the same frequency, 11 percent, as the nonminority elderly, which were 10 percent.

Although the Older Americans Act has provided funding for programs designed to serve all persons aged 60 and over, there has been an increasing awareness by our organization that minority older persons have unique service needs. Over 4,500 older minorities receive services annually from the Area Agency on Aging. Sixty percent are Hispanic and 4 percent are Native Americans. However, little information is available which substantiates the difference in needs among the minority groups of older adults. We do not have specific documentation to determine the mental health needs of the Hispanic elderly versus the Native American elderly or other older adults. We do know that nearly twice as many older minority adults receive services from senior centers as from any other service agency.

The Community Mental Health Centers—CMHC's—in the Denver metropolitan area offer varying levels of service for older persons. Services developed specifically for this population include: assessment procedures, group counseling, case management, peer support counseling, nursing home outreach services, and inpatient geriatric treatment programs. The level of services developed for this older group is somewhat dependent on staff patterns at CMHC's, in that the availability of geriatric specialists assures the development of specialized services for this population. The initiation of outreach services have been difficult because of funding problems in that Medicaid will only reimburse centers for services offered on-site.

As with the national scene, the mental health problems of older persons in the Denver Metropolitan area do not receive the attention they need from public and private agencies serving this population. Research dollars are needed to highlight the unique mental health needs of the different ethnic groups of older adults. Effective outreach services need to be developed which address the unique problems of older persons as well as their resistance to mental health services. The move to develop clinically-sound peer support groups located at nonthreatening facilities, such as senior centers, needs further support, particularly since so many older minorities use senior centers.

In addition, the mental health needs of nursing home residents and older residents of other facilities, such as board and care homes, need to be addressed. Because of funding cutbacks and continued problems with Medicaid funding, cost effective mechanisms for service expansion need to be explored. Cooperative working relationships should be developed between Older Americans Act-funded programs and those supported by the mental health system, particularly community mental health centers. Older Americans Act funds should be increased to address the mental health needs of older adults, particularly older minority adults. To facilitate awareness about the emotional and mental health issues of older persons, from both treatment and prevention perspectives, training

for service providers and nursing home staff needs to be implemented.

The growing awareness of these problems on the part of the mental health system and the range of service providers serving older populations needs public and financial support if mental health services are to be institutionalized as components of our service delivery system.

On behalf of the Denver Regional Council of Governments, I want to thank Representative Roybal and the House Select Committee on Aging for sponsoring this valuable public hearing, and to thank the committee members for their support of our Area Agency on Aging and of aging issues in Colorado.

The CHAIRMAN. Thank you, Ms. Snyder, for very good testimony.

The Chair would like to recognize someone that I consider my personal friend and someone who has shown over the years great interest, not only to problems of the aging, but the problems of humanity.

In the Congress of the United States, one many times has to struggle to get support on various issues, but not in the case of Ms. Schroeder when it comes to issues that affect, number one, her district, the State of Colorado, and the Nation.

With that kind of attitude, one can be sure of support for programs that are initiated by the Committee on Aging, Health and Education, those committees that I think deal with the problems that affect the people of America.

I happen to like Ms. Schroeder because she tells it like it is and has done so on many occasions, particularly with regard to the problems that affect minorities throughout the United States.

May I recognize at this time, Ms. Schroeder?

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. SCHROEDER. Well, thank you very, very much, Mr. Chairman, and I want to thank you and the committee for coming here for a field hearing.

You have included Denver many times. We appreciate your always coming out to get input from people because I think it makes a lot more sense than just sitting up in Washington in those marble rooms where everybody is interrupted every 10 seconds, and we really, really appreciate your being here.

I do not sit on the Chairman's committee. I do anything he ever comes up with for legislation because, let me tell you, I am a fan of his. He is the one that keeps coming up with incredibly sensitive legislation, and I sit on another committee that is absolutely awful. It is the other way, where we sit around and listen to testimony about horrible scenarios in the Armed Services Committee. So, this is wonderful that I can be here and when I see him struggling for a few pennies to make life better, I think of what they waste in 5 minutes on that committee. It breaks my heart.

So, it is an interesting bridge. I was apologizing to the Chairman that I could only drop by for a few minutes because I have a speech that I have to give at noon. It has been on forever, and I could not get out of it, but let me just say several things.

This is terribly important, as the Chairman knows, because in 1981, the White House Conference On Aging suggested and recommended that geriatric mental health really focus on ways to become more sensitive and aware of the ethnic differences, and since 1981, it just has not happened.

So, I think what the Chairman is doing is critical, and I think what we find when we look at mental health, as everybody here knows because they are out there dealing with it every day, is that it is very hard to find a comfort zone for older people to deal with it. Somehow saying that you are going to a mental health clinic is not what you are supposed to do if you are an older American and for different ethnic groups, it also is.

You are talking about how we get it into the community and find an area that is a comfort zone so it is really used. That is very important.

I think we tend to only fund also in this society things we fear, you know, and we do not fear the elderly. If you look at the suicide rate among men over 75, clearly it is the highest of any category in the country. So, there is obviously some real problems with depression and many other things and, yet, we do not fear men over 75, and, so, there is not a real drive to go out and try and figure it out.

Whenever we become afraid of something, then, oh, boy, here we come, we will throw money at it whether it has any relationship to solving it or not. So, I really do not have anything to add, Mr. Chairman, except that I am so glad you are here again and that you are looking at this because our community has a very, very strong Hispanic community that we are very proud of, and also a Native American community, and it is especially difficult for them because they come from many different reservations and different parts of the country.

So, while we look at them together as a culture, many of them came from different cultures and there is a further breaking down of cultures there that is hard to be sensitive to, and we keep wanting to pigeonhole and, of course, in Colorado, where we have transportation problems that hopefully you do not have quite the snow storms in Southern California we do, but for our seniors, transportation becomes such an important component of getting the services, too, because they are afraid to drive.

My favorite story, I wish you had been there because you would have loved it, Mr. Chairman, I was at a senior clinic on the west side and four women came in for one woman's physical, which I felt was a little extraordinary. When you go get a physical, you do not get all of us to come with you.

Finally, I said to them, you know, it is wonderful you care so much about your friend, but why did you all come, and they said she is the only one left that can drive. And it was, by golly, they were going to keep her healthy because she was their means to getting around and I think that really tells you something.

It seems that no matter what ethnic group we cut across in Denver, when we ask the aging population what they are most concerned about, transportation comes out as one of the leading things, and we keep having the joint budget committee and other people trying to cut that and only make it worse.

So, thank you for being here and I apologize for having to run out to a speech, but any time you can come to Colorado, we will give you the key to the city and the State.

The CHAIRMAN. Thank you very much.

As long as you continue supporting the committee, you do not have to give me the key to the city.

Ms. SCHROEDER. Okay.

The CHAIRMAN. Thank you very much.

We will now proceed to asking questions of the panel.

Dr. Baler, you discussed a program that you said was established on the local level, then you made various recommendations. Number one, if I remember correctly, was the change in Medicare. Changes perhaps in the training procedures and so forth. The change, and I am sure this is what you said, the changes that are to be brought about in the training institutions, in the training of individuals to serve specific communities.

Dr. BALER. Correct.

The CHAIRMAN. Now, I wanted to ask if I was correct in that assumption, that you also recommended change in approach by training institutions.

Dr. BALER. Yes, I do. There is at best, I think, an informal link between service providers and training institutions, and the amount of influence that service providers have on what the curricula are in various training institutions can be a matter of personal equity, chance, informal relationships, et cetera. As we are trying to look at developing a service system which is able to do more outreach, which is able in the public sector to have specific kinds of expertise then we have to draw our person power out of the training institutions. Very often, they are busy teaching things which are not representative of the kinds of service demands and service orientations which we demand in the community.

Again, most mental health students, whatever the profession, are still used to the idea that their lives may be carried out in an office after they get out of school, and that in that office, they may have reasonably regular hours.

As we are trying to develop service systems which can meet people, and various groups, including the elderly, who do not wish or who feel uneasy about coming in to offices, particularly at first, I think we need to go back to some of the old concepts of the street workers and urge medical health professionals to carry out their trade in other people's territory.

This is only one example.

The CHAIRMAN. What about the actual preparation that must take place, and I mean preparation by the individual that goes out into the community?

First of all, he has to go to school. Now, the problem is that most individuals that go into medicine as a whole go into medicine for the purpose of becoming rich some day.

Now, I say that not in criticism. I say that solely because of statements that have been made, even before the committee, with regard to the objectives of individuals going into the general field.

I also have been told by educators that Hispanics, Indians and other members of minority groups are not going into fields such as social work any longer. They are not going into any of the disci-

plines, health disciplines, that actually makes it necessary for them to work in the community itself.

My question is, how can we bring about a change of attitude that would make it possible for these students to go back to basics again? What I am saying is that I am dissatisfied with what I see in universities. I do not see enough people going into social work, into these related areas that we have been talking about today.

Do we have to provide scholarships? What do we have to do to change that around? I am going to ask the three of you that question.

Dr. BALER. I would like to start by saying it is my understanding that the percentages of various minorities in under-graduate education in this country has gone down in the last several years. We need to look not only at graduate education but under-graduate education in the sense of being able to go back to years in which those percentages were going up. I think they did go up for a number of years, not to where they should be.

In the operation of service agencies, we have a variety of people without degrees who are working for us. Very often those individuals end up doing lots of outreach and working very well.

We need to provide some kind of access for our staff to be able to gain academic credits and to become enrolled in academic programs.

Some would not have been able to think as a young person of going into college. Now we have a number of people in our work force, who given some scholarships, given some attention and given again a close relationship between the service organization and the training institution, there could be provided different career ladders for people.

The CHAIRMAN. Ms. Gallegos, do you have anything to add?

Ms. GALLEGOS. I strongly endorse that. Incentives need to come in a variety of forms, scholarships for one. We also need creative and innovative incentives to keep people in the human service categories. Outreach services and professional services in the community are essential to the elderly, and must be provided in the home or close to the home.

The CHAIRMAN. Ms. Snyder?

Ms. SNYDER. Building on the last response, I think that the reason people are not in the communities is because there are not jobs in those communities. We have the funding problem again, which unfortunately sometimes sounds like an easy response, but I think it is at the base of some of these issues.

In the Denver Metropolitan area, there are not a lot of jobs for geriatric social workers. It is a tight market. The competition is terribly stiff, and so it is difficult then to encourage younger people to start to go through years of expensive training for those positions if the jobs are not going to be there.

I would also recommend more training at different levels. Training for para-professionals, training for associate degrees in colleges that are more accessible to people of all ages—older people, too—who can go back to school and get enough training to begin work in the mental health field.

The CHAIRMAN. Ms. Gallegos, I was interested in your description of what is being done on the State level.

Now, what measures have the State of Colorado taken to specifically target the programs that address the mental health needs of Hispanics and American Indians?

Ms. GALLEGOS. Unfortunately, the steps that have been taken are inadequate and the resources are inadequate. The State of Colorado through a funding mechanism purchases mental health services from community mental health centers. State dollars flow from the State of mental health authority to each one of the community mental health centers in some type of a performance contract.

That performance contract indicates that that particular center will provide X amount of services to children and adolescents, to chronic mentally ill, to minorities of different kinds in the State, and to the elderly, and it does not specifically categorize the elderly into Hispanic or American Indian, but within all of the populations that we want them to serve, there has to be some percentage of Hispanic or the American Indian population.

The CHAIRMAN. Ms. Gallegos, I believe that those programs that are now in place are inadequate, not only in Colorado, as you have stated, but in every State in the Union, and particularly when it deals with the overall problems of the aging.

The one concern that I have is the lack of focus on the problems of the Indian and Hispanic communities.

So, I want to ask a question of Dr. Baler, Ms. Gallegos and Ms. Snyder.

In your opinion, what actions should be initiated by the Federal Government to assist your respective offices in becoming more effective in meeting the needs of the Hispanic and American Indian elderly?

I would like to have your verbal response, and if you feel that you need to add more to it, you may submit additional testimony in writing.

In other words, we need your help. How can we or what can we do to make available the necessary facilities so that you with your contribution can go out and do a better job in meeting the needs of the Hispanic and Indian communities?

Would you like to start on that, Ms. Gallegos, first, and then Ms. Baler and then Ms. Snyder?

Ms. GALLEGOS. I agree with you. There is no question about the fact that mental health services to the Hispanic and the American Indian population are very, very inadequate.

Ms. Schroeder stated earlier that we usually give monies to those populations that probably holler the most or are creating the most problems. At this particular time, that population nationally has been identified as the chronic mental ill.

The things that we need to do and which I strongly feel are required, I enumerated in my 10 remarks as I made in my opening statement. In order to achieve any of those things, we need to refocus on the specific and unique needs of the elderly population both the Hispanic and the Native American Indian elderly.

A lot of work needs to focus on identifying the needs across the urban population as well as the rural areas.

The CHAIRMAN. Ms. Gallegos, what I am referring to is what you mentioned in your 10 recommendations, the recommendations that you have made were not in your written text, and I would just like

to have you follow that up, give me those 10 recommendations that you have, then add to them, and you will help the committee greatly if you would do that.

Ms. GALLEGOS. I certainly will.

The CHAIRMAN. I thank you.

Ms. Baler.

Dr. BALER. Again, I would be glad to submit written testimony later.

I think in review, you can help us by trying to promote the legislation to expand mental health benefits through the Medicare system that I know you have planned.

I think you can help by taking another look at the national denial of the previous Medicaid waivers about which Fred Acosta spoke.

I think you can help by targeting and putting certain kinds of regulations and requirements on various sorts of mental health training funds, and also ensure that those funds continue, and I think you can help by having hearings like this.

The CHAIRMAN. Ms. Snyder?

Ms. SNYDER. Well, I certainly support both of those responses.

We need information on barriers and on the unique needs of this population, information that comes out of the kinds of research that Dr. Manson does.

We need more emphasis and legislation on targeting of those populations. The new version of the Older Americans Act has strengthened language that targets our efforts to addressing the needs of older minorities, and I think you get a response when you send that message to us at the local level.

We need more requirements in the legislation that is written for coordinated planning at every level from the local level to the Federal level. When Colorado has to apply for three separate Medicaid waivers and they do not interface, people get dropped out of those systems.

We talk today about increased funding for Medicaid, yet I know that our State legislature has just passed a budget that cuts our Medicaid transportation by 30 percent. Thus even if there are more services available, people are not going to be able to get to them.

And, again, I come back to the fact that the funding for these services is not adequate whether it is through the Older Americans Act or through mental health funding.

The CHAIRMAN. I wish that we had more time to continue the questioning, since the information provided has been extremely helpful.

I would like to thank Dr. Baler, Ms. Gallegos and Ms. Snyder, for very excellent testimony, and again I do not want you to forget the last question. I would like you to reduce that to writing, to send it to us, and so that we can review it and make use of it.

I would like to also thank Dr. Manson and his staff for their assistance in making this hearing a success.

We will go back to Washington, D.C., and review all of the testimony for purposes of developing a committee report. This report will be made available to all interested parties as well as State legislators, governors, and others involved in the legislative process.

Then, the committee will sit down and see what we can do with regard to making recommendations to Members of the House of Representatives, and the drafting of key legislation.

As good as a piece of legislation can be, there is always a strong element that opposes it, and I do not have to name those groups. You know them as well as I do. But they do exist.

So, again, we have to adhere to the political realities that exist, which clearly point out that those of us in the Congress need more help than anybody else. We need letters from you to go to those people who oppose us, to see if the change of attitude somewhere can be brought about and then I think that we can start passing pieces of legislation that will be meaningful.

We have to what we have and eliminate those things that are not working and replace them with things that do work. The pressure starts on a very local level and that local level is Washington, D.C. So, you see, we have many problems that are associated with any piece of legislation, but particularly problems associated with change, and I think that if we do not change what does not work, we are never going to accomplish those things that we have been discussing today.

So, I would like to thank each and every one of you for being present, for your testimony, and to announce also to those who are here, who have been listening to us, that we will keep the record open for 2 weeks.

I saw one or two people who raised their hands wanting to add something to the discussion. Well, the rules of the committee and the Congress do not permit that, unless we open it as a public hearing. This is not intended as a public hearing.

But anyone who has heard the discussion and would like to add something to it, please put it in writing and send your recommendations to the House Committee on Aging, Washington, D.C. That is all you have to remember.

May I again thank you for your courtesy and for your participation?

The hearing is adjourned.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF JANE HEADSTROM

The Colorado Commission on Aging commends the Royal Committee for addressing the special mental health needs of Native Americans and Elderly Hispanics. The Commission recognizes that the cultural background of Native Americans and Hispanics does give rise to nuances of problems which deserve unique solutions.

While we ensourage the committee to support increased medicare and medicaid benefits for mental health services to meet the growing prevalence of depression and alchololism among all elderly, we also encourage the development of special community based services to serve distinct populations.

MENTAL HEALTH
AND THE RURAL ELDERLY

TESTIMONY BEFORE

THE HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON AGING

SUBMITTED BY

TERI SCHAFER-NELSON

PROJECT COORDINATOR,

RURAL ELDERLY OUTREACH PROJECT

MAY 27, 1988

Mr. S. had been deeply concerned about his wife for several years, not knowing where to turn for help. He had confided to his personal banker that his wife was ,"just not herself." She was no longer the happy, busy woman that he had been married to for years, but a sad, isolated and suspicious woman. She also was convinced that the devil was sending messages to her from the roof of the house, and refused to leave their home. Mr. S. was so distraught by his wife's changes that he himself became sick and was hospitalized. He did not know where to turn for help, and was embarrassed to discuss the problem.

Mrs. D. became depressed after the death of her husband. She lost all appetite, all interest in her own care, and slept during most of the day. Friends expressed concern as she became more isolated, but she convinced them that she was fine, just needed, "time to myself." Her family lived in another state, but maintained regular contact with her. She had also convinced them that she was doing fine, until they came to visit. They discovered that she had not been taking care of herself or her home, she was worried and anxious, and seemed somewhat confused. There seemed to be no place to turn in this rural community where she lived, so they took her home to their state. The family admitted their mother to the local University Hospital and had her evaluated. She was diagnosed with severe depression, hospitalized and treated. During the discharge planning, the patient insisted on moving back home. She did not want to,"impose" on her family any longer, and missed her friends and home. Her family was deeply concerned that she may become depressed again, and they would have difficulty monitoring her at such a distance. What could they do?

The preceding true examples demonstrate the crucial need for mental health services for the rural elderly. It is also apparent that an alternative service delivery system would more effectively serve them, other than traditional out-patient services located in a mental health center. Rural elderly made up 10% of our population in the 1980 census. Estimates from a number of studies indicate that between 10 - 25% of rural elderly are at high risk for mental illness. (1) Despite the clear need for services, rural elderly only account for 2 - 6% of community mental health center's (CMHC) clients nationally, and less than 2% of the caseload of private psychiatrists. Many times the person remains uncared for at home with treatable conditions which increase in severity as time goes by. Help is not sought until a crisis necessitates hospitalization or long-term institutionalization. This disastrous and expensive outcome in many cases could have been avoided with early mental health intervention.

Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression. (2) There are additional stresses which exist in rural areas today, which can increase the risk for development of mental illness. When one considers the

statement, "healthy communities help sustain healthy individuals," one can better understand the increasing plight for elderly in economically devastated rural areas. Since the beginning of the farm crisis, many of these areas have suffered economically, losing banks, schools, businesses, and families. This in turn decreases the formal and informal support available for the elderly. Increased isolation and limited social and medical resources increase the likelihood that correctible sensory deficits or illnesses will remain undetected and untreated. Other aspects of rural living affect the wellbeing and mental health of the elderly. Consider the findings of these rural studies. It has been shown that a much higher proportion of rural elderly, in comparison to urban elderly, have income below the poverty level. (3) Rural elderly occupy a disproportionate share of the nation's substandard and dilapidated housing. (4) They exihibit more health problems which tend to be more severe, in comparison with urban elderly, and that result in a larger percentage of them retiring for health reasons. (5) There is more alcohol abuse amoung rural elderly, compared to urban elderly. (6) Health and mental health impairments are not as readily treatable in rural areas, as human services are less abundant, less accessible, and more costly to deliver that the in the urban areas. (7) Transportation is a problem, with little or no public transportation, and poorer roads for those who do drive.

The rural elderly include the group of elderly family caregivers who provide assistance to their older relatives, or disabled younger relatives. It is not unusual to find a elderly son or daughter or in-law, providing assistance to an older father or mother. Increasing resistance to formal services, by elderly and their families, seems to be higher in rural areas, as people struggle to remain self-reliant and independent. They may turn the family and friends for assistance first before turning to the formal service network. The increasing elderly population, decreasing younger population, and the economic decline of some rural areas, combine to create a tremendously stressful situation for elderly family careproviders, which at times can lead to elder abuse. Research is beginning to show older caregivers at high risk for experiencing depression, and anxiety, to name only a few of the mental health problems noted. This is related to the physical, emotional, mental, and financial exhaustion that can accompany the balancing act of caring for self, family, and an older relatives.

The Linn County Community Mental Health Center has developed an outreach program to identify and deliver outpatient mental health services to the rural elderly. The NIMH demonstration project was developed with the hopes of addressing the mental health needs of rural elderly more effectively and completely. Through the support of the Abbe Center for Community Mental Health, the State of Iowa's Division of MH\MR\DD, the Administration on Aging, and the

National Institute of Mental Health, an in-home, multidisciplinary team was funded to identify, assess, and treat mentally ill elderly in their own homes. This project had been in operation for two years, and has successfully addressed a number of problems related to treating the mentally ill rural elderly. First, there was the problem of identifying those in need of treatment. Gatekeeper Training, a concept developed by Ray Rascko from the Spokane Community Mental Health Center, was developed for the project's rural catchment area. Gatekeeper Training involves the training of lay and professional people in identifying signs and symptoms of mental illness. These people are called "gatekeepers" because they can open the "gates" for those in need of services, to the agencies providing those services. Once someone is identified as in need of services, the "gatekeeper" refers them to the local mental health center, or the most appropriate agency. This method of identifying elderly mentally ill can be especially successful in the very rural areas, where many high risk elderly may be quite isolated. Meter readers from the local utilities company, or mailmen may be the only contact that some older isolated people have with the outside world. To train these groups and others in the communities, allows for better, possibly more timely referrals, preventing crisis intervention when the person may be beyond help. Gatekeeper Training is economical, practical, and a wonderful way to make use of available and valuable community resources, (the community members). Well-elderly clinic staff nurses recieved the training, as well as other elderly agency's staff, to assist them in feeling more comfortable in identifying their clients who may be in need of mental health services. Other referrals came from discharge planners for the locazlhospital psychiatric units, or mental health institutions.

Another problem that was successfully addressed through the outreach project was that of providing mental health assessment and treatment to mentally ill elderly, once they were identified. Barriers such as transportation problems, cost, being homebound due to physical or mental health problems, and the stigma attached to recieving mental health services, or a lack of understanding of mental illness and it's treatment, can prevent many elderly from seeking services at a mental health center. By providing services through a mobile outreach team, in the homes of older people, many of these problems were addressed. A nurse or social worker can make the initial visit and assessment, and refer on to other team members for further assessment and treatment if needed. Education about mental health, as well as support,and advocacy were provided to the older person, as well as referral to other medical and social service agencies for additional help. Education for the older person's family was also provided, and referrals to support groups and other community resources. The program was

funded by grants, therefore, no fee was charged for services.

The Rural Outreach team has seen many happy endings. For Mr. S., his personal banker knew where he could go for help. Earlier that year, his bank had participated in Gatekeeper Training. With his client's permission, the personal banker referred him to the local CMHC. A staff person listened to his story, and encouraged him to consider an in-home assessment of his wife by the Outreach Team. The team psychiatrist eventually got in the door and assessed Mr. S.'s wife. The evaluation showed a severely depressed woman, who was at the point of experiencing hallucinations. The Outreach team was then able to work with Mr. S. on getting appropriate treatment for his wife. In the case of Mrs. D., the discharge planner from the University Hospital made a phone call to the nearest community mental health center, and discovered that they had an Outreach Project that could provide follow-up in the patient's home. The patient was relieved because she did not drive, and if she did, the closest center for services was about twenty-five miles away. The family was relieved, and knew that they could feel comfortable allowing their mother to move back home, and that they had a contact person who could monitor her progress or any decline.

Though there are successes, there are still problems which need to be addressed in regards to best serving the mental health needs of rural elderly. Though outreach teams are successful, they are costly. Transportation costs, (including staff time spent driving, car maintenance and gas) can be quite high. Many community mental health centers cannot afford outreach teams due to this factor, as well as the problems with in-home reimbursement for mental health services. Cooperative ventures amoung community hospitals, medical centers or other agencies can be one way begin to address these problems, but without funding or incentives to work out territoriality issues, these type of projects are rare. Examples of this type of cooperative effort are a hosptial and mental health center providing complete assessments for elderly, in an attempt to diagnosis dementia, or medical centers housing a mental health therapist within their building to refer older patients to. Preventive services, such as respite care for rural care providers, often are not available, or are too costly. Often the training of qualified respite workers is ignored, so services that are provided are inadequate.

The mental health needs of the elderly have long been ignored, with many believing that older people do not suffer from mental illness, or are not responsive to mental health treatment. The Rural Ourtreach project identified three-hundred elderly people, within it's first two and a half years of operation, with mental illness, or at high risk for developing mental illness. Research has shown for years that the elderly are just as responsive to chemotherapy and psychotherapy, as younger clients. The

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time to act is long overdue. Working together to better serve the needs of mentally ill elderly will benefit not only the client, but their families, and society itself.

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